CHICAGO & VICINITY LABORERS' DISTRICT COUNCIL HEALTH & WELFARE PLAN

Important Notice of Change to Benefits under Active Plan 1

August 2022

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 and updates to the benefits under Active Plan 1 for eligible claims incurred on or after June 1, 2022 as required by the No Surprises Act:

No Surprises Act Services

The No Surprises Act requires significant changes to the Plan and offers many protections to eligible participants for the following types of non-network claims:

- Non-network Emergency Services (including Post-Stabilization Services);
- Non-emergency services performed by non-network providers at in-network Health Care Facilities who fail to obtain participants' express prior consent;
- Non-emergency Ancillary Services (including anesthesiology, pathology, radiology and diagnostics) when performed by non-network providers at in-network Health Care Facilities; and
- Non-network Air Ambulance Services.

Please see the addendum below for detailed definitions and explanations of each of these claims.

In general, in these circumstances where the No Surprises Act is applicable, you cannot be balanced billed by the non-network providers or non-network facilities and the Plan will cover the claims as if the services or items were provided by an in-network provider or facility.

In general, the Plan will cover No Surprises Act Services as follows:

- Any Coinsurance payment that the Plan makes for such Claims (after the Plan pays the first $10,000 in covered expenses and you and your family have satisfied your annual deductible) will be at the in-network rate (90% instead of 80%).
- Your cost sharing payment (that is, your share of any Coinsurance—10% for No Surprises Act Services) will be based on the "Recognized Amount" for these services. Until further guidance is issued, the Recognized Amount (defined in detail below) will be the lesser of the provider's billed charges or the Qualifying Payment Amount (defined generally as the median contracted rate for the item or service in the geographic region) and for Air

Ambulance Services, the lesser of the provider's billed charges and the median contracted rate for such services.

- Any Coinsurance payments you make with respect to No Surprises Act Services count toward your out-of-pocket maximum in the same manner as if those services were provided by an in-network provider.

<u>Continuing Coverage with a Provider who Leaves the Plan's Network</u>

If you are a Continuing Care Patient (as defined below) and the Plan terminates its contract with your in-network provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

- Notify you in a timely manner of the Plan's termination of its contracts with the in-network provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and

- Allow you ninety (90) days of continued coverage at the in-network amount to allow for a transition of care to a network provider.

<u>Services or Supplies Obtained from a Non-Network Provider Believed to be an In-Network Provider</u>

A list of network providers is available to you without charge by visiting the Plan's website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as those in general practice, who are contracted with the Plan's network.

If you obtain incorrect information from the Plan about whether a provider is an in-network provider and you seek care from that provider, the Plan will cover the services as if the provider were, in fact, an in-network provider as follows:

- Apply any Coinsurance amount as if the provider was an in-network provider; and

- Apply any Coinsurance amount toward the out-of-pocket limit as if the services were provided by an in-network provider.

<u>External Review of No Surprises Act Claims</u>

If your initial claim for benefits related to a No Surprises Act Services has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination.

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. 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 to the SPD/Plan: The following conforming changes are made to the section references contained in the Active Plan 1 SPD/Plan, effective June 1, 2022:

1. In the section entitled "How The Medical Plan Works", on page 18 of the SPD/Plan, the first paragraph is amended to read as follows:

   You are covered for expenses you incur for most, but not all, medical services and supplies. Please see page 28 for the list of exclusions. Your expenses must be Medically Necessary to be eligible for coverage. All charges for your care are subject to Usual and Customary Charges. Benefits are paid on a calendar year basis. If you or a dependent use a non-network provider, you are responsible for any expenses you incur that exceed Usual and Customary Charges unless the claim is subject to the No Surprises Act. See page 92 for the definition of Usual and Customary Charges. For claims subject to the No Surprises Act, you will generally be responsible for Coinsurance calculated at rate for in-network providers based upon the Recognized Amount.

2. In the section entitled "Coinsurance", on page 19 of the SPD/Plan, the third paragraph is amended to read as follows:

   Note: These estimated Coinsurance amounts are applicable to expenses covered by the Plan only. All charges are subject to Usual and Customary Charges and may result in a payment of less than 100% if a non-network provider is used unless the claim is subject to the No Surprises Act. For claims subject to the No Surprises Act, you will generally be responsible for any Coinsurance calculated at the rate for network providers based upon the Recognized Amount.

3. In the section entitled "Medical Covered Expenses", on page 22 of the SPD/Plan, the first paragraph is amended to read as follows:

   The Plan covers the actual Usual and Customary Charges for the following listed Medically Necessary services and supplies unless the claim is subject to the No Surprises Act. Limitations on the number of treatments and the dollar amount for such treatments are

contained in this section and on the *Schedule of Medical Benefits* on page 21. For claims subject to the No Surprises Act, you will generally be responsible for any Coinsurance based upon the Recognized Amount.

4. In the section entitled "Medical Covered Expenses", on page 22 of the SPD/Plan, the first bullet in the "Usual and Customary Charge" callout box is amended to read as follows:

USUAL AND CUSTOMARY CHARGE:

- The charge that is no higher than the 95th percentile of the Plan's most currently available healthcare charge data, or where there is insufficient data, a value or amount uniformly established by the Plan for that charge unless subject to the No Surprises Act;

5. In the section entitled "Schedule of Medical Benefits", on page 21 of the SPD/Plan, the language found in the section entitled Medical Coinsurance, Benefit/Limitations under the Annual Deductible is amended as follows:

Medical Coinsurance	After you pay your annual deductible, the Plan pays the applicable Coinsurance rate of the next $7,500 per person of eligible expenses each calendar year; the Plan then pays 100% of additional expenses incurred during the calendar year
Network Provider and Claims Subject to No Surprises Act	Plan pays: 90% of $7,500 of covered expenses, after the deductible; then 100% incurred during the calendar year
Non-Network Provider	Plan pays: For claims not otherwise subject to the No Surprises Act, 80% of $7,500 of covered expenses, after the deductible; then 100% incurred during the calendar year.

6. A new section entitled "Covered Expenses Subject to the No Surprises Act", is added starting on page 28 of the SPD/Plan is added following the section entitled "Medical Covered Expenses" of the SPD/Plan to read as follows:

Covered Expenses Subject to the No Surprises Act

The No Surprises Act requires significant changes to the Plan and offers many protections to eligible participants, including protections to participants in an emergency situation or when a non-network provider treats a participant at an in-network Health Care Facility without the participant's express consent or when a participant uses a non-network Air Ambulance Services' provider. In general, in these circumstances, you cannot be balanced billed by non-network providers or non-network facilities if the claim is subject to the No Surprises Act.

The following information relates to otherwise covered expenses, subject to the No Surprises Act. Eligible participants are still encouraged to use network facilities and network providers whenever possible.

Claims subject to the No Surprises Act are covered as follows:

- *Emergency Services*

  The No Surprises Act requires Emergency Services to be covered as follows:

  The Plan will cover Emergency Services provided at a non-network facility or by a non-network health care provider in the same manner as in-network Emergency Services. This means the following with respect to how Emergency Services are covered in such situations:

  - In general, you cannot be balance billed for covered Emergency Services.

  - If you are required to make a Coinsurance payment, you will pay the same in-network Coinsurance rate (10%) whether you receive covered Emergency Services from a non-network facility or provider or in-network facility or provider. Your Coinsurance amount, if any, will be based on the Recognized Amount payable for these services.

  - Any Coinsurance payments you make with respect to non-network Emergency Services will count toward your out-of-pocket maximum in the same manner as if those claims were provided by an in-network provider.

  - The Plan will not impose more restrictive administrative requirements on non-network Emergency Services than on in-network Emergency Services.

- *Non-Emergency Services*

  The Plan will cover non-emergency items or services from a non-network provider who is working at an in-network Health Care Facility in the same manner as if the non-emergency items or services had been furnished by an in-network provider.

  The non-emergency items or services received from a non-network provider working at an in-network facility will be covered at the in-network Coinsurance rate (if applicable) as if the items or services had been furnished by an in-network provider.

  - In general, you cannot be balance billed for these non-emergency items or services.

  - If you are required to make a Coinsurance payment, you will pay the in-network Coinsurance rate as if the items or services were received from an in-network facility or provider. Your Coinsurance amount, if any, will be based on the Recognized Amount payable for these services.

  - Any Coinsurance payments you make with respect to covered non-emergency services will count toward your out-of-pocket maximum as if the services were provided by an in-network provider.

- In certain circumstances, you can be billed by a non-network provider who works at an in-network facility. This can occur if you are notified by the non-network provider that they do not participate in the network. The provider must give you a notice stating certain information required by federal law, including that the provider is a non-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any network providers at the facility who are able to treat you, and that you may elect to be referred to one of the network providers listed. If you give informed consent to be treated by the non-network provider, then the Plan will pay for these services at the non-network Coinsurance rate (if applicable) based on the Usual and Customary rate, and the provider can bill you for the balance directly. This rule does not apply to services provided by hospital-based providers for Ancillary Services, such as anesthesiologists and radiologists.

Notice and Consent Exception

Non-emergency items or services provided or performed by a non-network provider at an in-network Health Care Facility will be covered based on the Plan's non-network provider benefits (80% of the Usual and Customary Charge for the first $7,500 after the applicable annual deductible has been satisfied) and forgo the financial protections of the No Surprises Act if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the patient (or their representative) is provided with a written notice, as required by federal law, that the provider is a non-network provider with respect to the Plan, the estimated charges for treatment and any advance limitations that the Plan may put on treatment, the names of any in-network providers at the facility who are able to provide treatment, and that the patient may elect to be referred to one of the in-network providers listed; and

- The patient gives written informed consent to continued treatment by the non-network provider acknowledging that the patient understands that continued treatment by the non-network provider will result in greater expenses.

- The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-network provider satisfied the notice and consent criteria. In such situations, the services will be covered as if the claims were provided by an in-network provider as follows:

  - For any applicable Coinsurance payment, the same Coinsurance rate will apply as if the items or services had been furnished by an in-network provider and will be based on the Recognized Amount for such items and services; and

  - By counting any Coinsurance payments toward your out-of-pocket maximum, as if such cost-sharing payments were made with respect to items and services furnished by an in-network provider.

- *Ancillary Services*

The No Surprises Act requires Ancillary Services provided by a non-network provider at an in-network facility to be covered in the same manner as in-network services.

Ancillary Services include emergency medicine, anesthesiology, pathology, radiology, and neonatology, services provided by assistant surgeons, hospitalists, and intensivists, diagnostic services, such as radiology and laboratory services, and items and services provided by a non-network provider if there is no network provider who can furnish such item or service at such in-network facility.

The Plan will provide coverage of Ancillary Services provided by a non-network provider an in-network facility as follows:

- For any applicable Coinsurance payments, the same Coinsurance rate will apply as if the items or services had been furnished by an in-network provider and will be based on the Recognized Amount for such items and services; and

- By counting any Coinsurance payments toward your out-of-pocket maximum, as if such cost-sharing payments were made with respect to services furnished by an in-network provider.

- *Air Ambulance Services*.

  The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

  - Air Ambulance Services from a non-network provider are covered as if the services had been furnished by an in-network provider;

  - Any applicable Coinsurance amount will be calculated as if the services had been provided by an in-network provider of Air Ambulance Services and will be calculated based on the lesser of the billed amount for the services or the median of the network's contracted rates with network providers; and

  - Any Coinsurance payments the participant or dependent makes with respect to covered Air Ambulance Services will count toward the out-of-pocket maximum in the same manner as those received from an in-network provider.

- *Continuing Care Patients*.

  If you or your dependent is a Continuing Care Patient and the Plan terminates its contract with an in-network provider or a network facility or Hospital, or benefits are terminated because of a change in terms of providers' and/or facilities' participation in the Plan, the Plan will do the following:

  - Provide notice of the Plan's termination of its contracts with the in-network provider or facility and inform the patient or their representative of the patient's right to elect continued transitional care from the provider or facility; and

  - Allow the patient 90 days of continued coverage at the in-network rate to allow for a transition of care to an in-network provider or facility.

A Continuing Care Patient is an individual who is: (a) receiving a course of treatment for a Serious and Complex Condition, (b) scheduled to undergo non-elective surgery (including any post-operative care); (c) pregnant and undergoing a course of treatment for the pregnancy; (d) determined to be terminally ill and receiving treatment for the illness; or (e) is undergoing a course of institutional or Inpatient care from the provider or facility.

In the case of an acute illness, a Serious and Complex Condition is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, a Serious and Complex Condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

- *Provider Directory.*

  A list of network providers is available to you without charge by visiting the Plan's website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as those in general practice, who are contracted with the Plan's network.

  The Provider directory will be updated at least every ninety (90) days. If a participant or dependent is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic provider directory that a provider is an in-network provider, but, in fact, the provider is a non-network provider and services are furnished by the non-network provider, the Plan will:

  - Apply any Coinsurance amount as if the provider was an in-network provider; and

  - Apply any Coinsurance amount toward the out-of-pocket limit as if the services were provided by an in-network provider.

7. In the section entitled ”Expenses Not Covered Under Medical Benefits”, on page 28 of the SPD/Plan, item 3 is revised to read as follows:

   3. Services or supplies that are not Medically Necessary or that exceed the Usual and Customary Charge <u>unless subject to the No Surprises Act</u>.

8. In the section entitled “Claim and Appeal Information”, which starts on page 57 of the SPD/Plan, the following new section is added after the section entitled “Appeal Review” on page 63 of the SPD/Plan:

   External Review of Claims Subject to the No Surprises Act

   If the initial Claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you or your eligible dependents are dissatisfied with the outcome of the Plan's internal Claims and Appeals process described earlier, you and your eligible dependents may (under certain circumstances) be able to seek external review of the Claim by an Independent Review Organization (“IRO”). This process is only applicable to Claims involving No Surprises Act Services.

Claims Eligible For The External Review Process

Healthcare Claims (Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims), in any dollar amount, are eligible for external review by an IRO if the denial involves surprise billing or cost-sharing issues that are protected under the No Surprises Act for Emergency Services, Ancillary Services, Air Ambulance Services, and non-emergency services provided by a non-network provider at an in-network Health Care Facility.

A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your eligible dependent fail to meet the requirements for eligibility under the Plan is not eligible for external review.

In general, you or your eligible dependents may only seek external review after receiving a "final" adverse benefit determination under the Plan's internal Claim Appeal and Appeal Review process. A "final" adverse benefit determination means the Plan has continued to deny the initial Claim in whole or part and you or your eligible dependents have exhausted the Plan's internal Claim Appeal and Appeal Review process.

Under limited circumstances, you or your eligible dependents may be able to seek external review before the internal Claim Appeal and Appeal Review process has been completed:

- If the Plan waives the requirement that you or your eligible dependents complete its internal Claim Appeal and Appeal Review process first.
- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which you or your eligible dependent's health may be in serious jeopardy or, in the opinion of their health care professional, you or your eligible dependents may be experiencing pain that cannot be adequately controlled while waiting for a decision on the internal Appeal.
- If the Plan has not followed its own internal Claim Appeal and Appeal Review process and the failure was more than a minor error. In this situation, the internal Claim Appeal and Appeal Review is "deemed exhausted," and you or your eligible dependents may proceed to external review. If you or your eligible dependents think that this situation exists, and the Plan disagrees, a request may be made to the Plan to explain in writing why you or your eligible dependents are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

A request for external review of a standard (not Urgent Care) Claim must made in writing within four (4) months after receiving notice of an adverse benefit determination.

Because the Plan's internal Claim Appeal and Appeal Review process generally must be exhausted before external review is available, external review of standard Claims will ordinarily only be available after receiving a "final" adverse benefit determination following the exhaustion of the Plan's internal Claim Appeal and Appeal Review process.

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

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

- You or your eligible dependents 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, they were covered at the time the health care item or service was provided;

- The adverse benefit determination satisfies the above-stated requirements for a Claim eligible for external review and does not, for example, relate to the failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage;

- You or your eligible dependents have exhausted the Plan's internal Claim Appeal and Appeal Review process (or a limited exception allows proceeding to external review before that process is completed); and

- The request is complete, meaning that you or your eligible dependents have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you or eligible dependents in writing whether:

- The request is complete and eligible for external review;

- The request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).); or

- The request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You or your eligible dependents must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after receiving notification that the request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If the request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of Claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of Claims.

Once the Claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you or your eligible dependents in writing that the request is accepted for external review.

- The IRO will explain how to submit additional information regarding the Claim. In general, additional information must be provided within ten (10) business days. The IRO is not required to, but may, accept and consider additional information submitted after the ten (10)-business day deadline; and

- Within five (5) business days after the Claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the Claim de novo, meaning that the IRO is not bound by the Plan's previous internal Claim Appeal and Appeal Review decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from you or your eligible dependent's medical records, any recommendations or other information from the treating health care providers, any other information from you or your eligible dependents, 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).

- In a standard case, the IRO will provide written notice of its final decision to you or your eligible dependents, and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) 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;

- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

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

- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon;

- A statement that the IRO's decision is binding on you or your eligible dependents, and the Plan, except to the extent that other remedies may be available to you or your eligible dependents, or the Plan under applicable state or federal law;

- A statement that judicial review may be available to you or your eligible dependents; and

- A statement regarding assistance that may be available to you or your eligible dependents, from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review of an Urgent Care Claim

- A request for an expedited external review may be made in the following situations if:

- You or your eligible dependents receive an adverse benefit determination regarding the initial Claim that involves a medical condition for which the timeframe for completion of an expedited internal Claim Appeal would seriously jeopardize life or health, or would jeopardize the ability to regain maximum function, and you or your eligible dependents have filed a request for an expedited internal Appeal.

- You or your eligible dependents receive a "final" adverse benefit determination after exhausting the Plan's internal Claim Appeal and Appeal Review procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize life or health, or would jeopardize the ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you or your eligible dependents received Emergency Services, and you or your eligible dependents have not yet been discharged from a facility.

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard Claim external review process). The Plan will defer to you or your eligible dependent's attending health care professional's determination that a Claim constitutes "urgent care." The Plan will immediately notify you or eligible dependents (e.g., telephonically, via fax) whether the request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard Claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of Claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of Claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The 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. In reaching a decision, the IRO must review the Claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal Claim Appeal and Appeal Review process. However, the IRO decision must not be contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard Claim external review process, as expeditiously as the medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you or your eligible dependent in writing, the IRO must provide written confirmation of the decision to you or your eligible dependent, and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed Claim. However, even after providing coverage or payment for the Claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed Claim.

- If you or your eligible dependent are dissatisfied with the external review determination, a judicial review may be sought to the extent permitted under ERISA section 502.

9. In the section entitled "Definitions", a new term is added in alphabetical order, on page 86 of the SPD/Plan as follows:

Adverse Benefit Determination	Adverse benefit determination means any of the following: 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 payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a 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.

10. In the section entitled “Definitions”, a new term is added in alphabetical order, on page 86 of the SPD/Plan as follows:

Air Ambulance Services	Medical transport services and supplies, as may be Medically Necessary, by a certified rotary wing Air Ambulance, as defined in 42 CFR §414.605, or certified fixed wing Air Ambulance, as defined in 42 CFR § 414.605, for patients.

11. In the section entitled “Definitions”, a new term is added in alphabetical order, on page 86 of the SPD/Plan as follows:

Ancillary Services	Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by a non-network provider at an in-network Health Care Facility, the term “Ancillary Services” means the following: • Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner, • Items and services provided by assistant surgeons, hospitalists, and intensivists; • Diagnostic services, including radiology and laboratory services; • Items and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and • Items and services provided by a non-network provider if there is no in-network provider who can furnish such items or services at such facility.

12. In the section entitled “Definitions”, the row “Eligible Charge” on page 88 of the SPD/Plan, is amended as follows:

Eligible Charge	In the case of a provider that has a written agreement with the Fund to provide care at the time Covered Services are rendered, the provider’s Claim charge for Covered Services. In the case of a provider that does not have a written agreement with the Fund to provide care at the time Covered Services are rendered, the amount for Covered Services as determined by the Fund Office, unless subject to the No Surprises Act, based on the following order: The charge that is within the range of charges other similar Hospitals or facilities in similar geographic areas charge patients for the same or similar services, as reasonably

	determined by the Fund Office, <u>unless subject to the No Surprises Act</u>, if available; The amount that the Centers for Medicare & Medicaid Services (CMS) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to those in the Medicare program; or The charge that the particular Hospital or facility usually charges its patients for Covered Services.

13. In the section entitled "Definitions", a new term is added in alphabetical order, on page 88 of the SPD/Plan as follows:

Emergency Medical Condition	A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

14. In the section entitled "Definitions", a new term is added in alphabetical order, on page 88 of the SPD/Plan as follows:

Emergency Services	Emergency Services means the following: An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and Within the capabilities of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished). Emergency Services furnished by a non-network provider or at a non-network Hospital (regardless of the department of the Hospital in which such items or services are furnished) or an Independent Freestanding Emergency Department also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of Outpatient observation or an Inpatient or Outpatient stay related to the Emergency Medical Condition, until:

	➢ The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and ➢ The patient or their representative is supplied with a written notice, as required by federal law, that the provider is a non-network provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and ➢ The patient or their representative gives informed written voluntary consent to continued treatment by the non-network provider, acknowledging that the patient understands that continued treatment by the non-network provider may result in greater costs to the patient.

15. In the section entitled "Definitions", a new term is added in alphabetical order, on page 89 of the SPD/Plan as follows:

Health Care Facility (for non-emergency services)	Health Care Facility (for non-emergency services) means each of following: A Hospital (as defined in section 1861(e) of the Social Security Act); A Hospital Outpatient department; A critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act); and An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

16. In the section entitled "Definitions", a new term is added in alphabetical order, on page 89 of the SPD/Plan as follows:

Independent Freestanding Emergency Department	A health-care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct from a Hospital under applicable State law and provides Emergency Services.

17. In the section entitled “Definitions”, a new term is added in alphabetical order, on page 90 of the SPD/Plan as follows:

No Surprises Act Services	The term “No Surprises Act Services” means the following, to the extent covered under the Plan: (1) non-network Emergency Services, (2) non-network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a non-network provider at an in-network facility; and (4) other non-network non-emergency services performed by non-network provider at an in-network facility with respect to which the provider does not comply with written federal notice and consent requirements.

18. In the section entitled “Definitions”, a new term is added in alphabetical order, on page 91 of the SPD/Plan as follows:

Qualifying Payment Amount (QPA)	The amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the Plan for the item or service in the geographic region.

19. In the section entitled “Definitions”, a new term is added in alphabetical order, on page 91 of the SPD/Plan as follows:

Recognized Amount	Recognized Amount means (in order of priority) one of the following: An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; An amount determined by a specified state law; or The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount. For Air Ambulance Services furnished by non-network providers, the Recognized Amount is the lesser of the amount billed by the provider or facility or the median of the network’s contracted rates with network providers.

20. In the section entitled “Definitions”, the row “Usual and Customary (U&C) Charge” on page 92 of the SPD/Plan, is amended as follows:

Usual and Customary (U&C) Charge	The charge that is no higher than the 95th percentile of the Plan’s most currently available healthcare charge data unless subject to the No Surprises Act: Where there is insufficient data, a value or amount uniformly established by the Plan for that charge;

	For multiple or bilateral surgeries performed at the same time, 100% for the primary procedures and an amount determined after medical review for the secondary procedures; and For surgical assistance by a Physician, up to a maximum of 20% of the charge allowed for the surgery. For PPO providers, Usual and Customary Charges are amounts that do not exceed the negotiated rate.

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Statement of the Plan's Grandfathered Status. The Board of Trustees of the Chicago & Vicinity Laborers' District Council Health & Welfare Fund believes this 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 a 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 (the "Plan") and is intended to be a Summary of Material Modifications to the SPD/Plan. The Board of Trustees of the Plan ("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 Trustees, or such other persons as delegated by the Trustees, have 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

August 2022