FOX VALLEY & VICINITY LABORERS

HEALTH AND WELFARE AND PENSION FUNDS

DATE: April 29, 2022

TO: Eligible Participants

FROM: Board of Trustees

SUBJECT: Fox Valley Laborers Health and Welfare Fund
Summary of Material Modifications

This letter is a Summary of Material Modifications to the Plan Document. Please read this letter carefully and keep it with your copy of the January 2019 Edition of the Summary Plan Description booklet. The letter contains information on changes to eligibility rules, certain defined terms, claim decision process and benefit coverage provided by your Health and Welfare Plan in order to comply with the No Surprises Act.

Eligibility – Continued Coverage for Active Participants

The Board of Trustees approved amending the Plan to extend the change in the "look-back" rule from 1,000 to 800 hours effective from the Benefit Quarter beginning July 1, 2022 and ending with the Benefit Quarter finishing June 30, 2023. Unless approved by the Trustees, effective with the Benefit Quarter beginning July 1, 2023 the "look back" rule will be 1,000 hours.

Therefore, effective July 1, 2022 to June 30, 2023 to continue coverage the Fund must receive either contributions from your employer for 270 or more hours of work during a contribution quarter or 800 hours or more of work in any four consecutive contribution quarters. The following chart shows how this works.

If you Earn 270 Hours or More During One of These Contribution Quarters	If you Earn 800 Hours or More During This 12-Month Period	You will be Eligible for Benefits During One of These Quarters
February, March, April	12 months ending April 30	July, August, September
May, June, July	12 months ending July 31	October, November, December
August, September, October	12 months ending October 31	January, February, March
November, December, January	12 months ending January 31	April, May, June

However, if you initially became covered because you earned 500 hours in a six-month period, and your coverage started in the middle of a benefit quarter, your coverage will continue through the end of the following benefit quarter.

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Retiree Eligibility

Eligibility for retiree health care benefits for retired employees retiring with a 30-and-Out benefit has been simplified effective June 1, 2020 to mirror the requirements for those retiring with an Early, Normal or Disability Pension as follows:

Retiree health care benefits are available to you if you meet the following requirements:

- you have at least 15 years of service under the:
    - Fox Valley and Vicinity Laborers Pension Fund, with a maximum of 50% of those years granted under reciprocal agreements; or
    - Fox Valley Laborers Health and Welfare Plan (for retiree eligibility purposes, a year of service is 500 or more hours of contributions made to this Plan on your behalf in a Plan year, which is June 1 – May 31); and
- you are receiving Early, Normal, 30-and-Out, or Disability Pension benefits each month from the Fox Valley and Vicinity Laborers Pension Fund and you were eligible for welfare benefits under this Fund for at least one benefit quarter within the four benefit quarters immediately before you retired.

Other provisions for Retiree Coverage listed in the Summary Plan Description continue to apply.

Dependents of Non-Bargained Participants

The Summary Plan Description is clarified to allow addition of your legal spouse to coverage outside of the Open Enrollment period upon marriage if the required enrollment information is provided within 30 days of the date of marriage.

No Surprises Act

The Board of Trustees adopted changes to the benefits to comply with federal legislation designed to protect Participants from surprise medical bills and add consumer protections effective June 1, 2022.

The new requirements help protect Participants from balance billing on certain medical bills incurred for Non-Network Emergency Services providers, Non-Network providers that are working at Network facilities, and Non-Network air ambulance services providers. Your cost sharing for these services will be based on an amount similar to a Network provider and the Non-Network provider generally cannot balance bill you for any difference between the full amount charged and the total of your cost sharing and what the Plan pays for the service. Any payment disputes between the Plan and the Non-Network provider must be handled through an Independent Dispute Resolution Process that does not involve you. There are limited circumstances involving non-emergency services where you may knowingly waive these protections after receiving prior written notice which includes certain required information.

Non-Network Emergency Services

Covered Emergency Services are treated as Network for determining all cost-sharing amounts, including the coinsurance, even if the services were received from a Non-Network Emergency facility. Your cost-sharing will be based on the Recognized Amount payable for these services.

The provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and coinsurance, or deductible amounts paid by you.

Non-Network Providers at Network Facilities

Unless you consent to receiving services from the Non-Network provider (as described here), covered services performed by Non-Network providers at Network facilities are treated as Network for determining all cost-sharing amounts, including the coinsurance. Your cost-sharing will be based on the Recognized Amount payable for these services.

The provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and coinsurance, or deductible amounts paid by you.

Non-Network Air Ambulance Providers

Covered air ambulance services are treated as though provided by a Network Provider for determining all cost-sharing amounts, including the coinsurance. Your cost-sharing will be based on the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

The provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and coinsurance, or deductible amounts paid by you.

Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. These protections may be waived when you visit a Non-Network Provider who works at a Network Facility or for services from a Non-Network emergency facility or provider after you are stabilized. This can occur if you are notified by the Non-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and to waive the protections. In this case, the Plan will treat these services as Non-Network which is subject to Non-Network cost-sharing; the provider can bill you for the balance directly, which is the difference between what the provider charges and the amount paid by the Plan and your cost-sharing amounts.

Continuing Care

If you are receiving care from a Network provider that becomes Non-Network, you may qualify for transitional care for up to 90 days at Network cost sharing. This applies if you are receiving treatment for a serious and complex condition, pregnancy, or terminal illness, undergoing inpatient care, or scheduled for non-elective surgery. Additional information is available by calling the Administrative office.

Provider Directory

Your Identification Card now has additional information and you will be receiving a new card soon. Please replace your current ID card with the updated replacement card when received. In addition, the list of network providers will be periodically reviewed, verified, and updated as required by law. You may call the telephone number on your ID Card or consult the provider list through the link on the Plan's website to determine if a particular provider or facility participates in the Plan's network. Your calls will be responded to as soon as practicable and no later than one business day after receipt, through a written electronic or print communication depending upon your request. Under certain circumstances, if you receive incorrect information about the "network" status of a provider or facility through the website or call and then receive covered medical services from it, you may only be responsible for the Network cost sharing amounts.

Notice Requirement

The Plan will be posting an important notice about "Your Rights and Protections Against Surprise Medical Bills" on the Plan's website as required by the No Surprises Act.

Complaint Process

If you believe you have been wrongly billed, or otherwise have a complaint under the No Surprises Act, you may contact the Administrative Office or the Employee Benefit Security Administration toll-free number at (866) 444-3272.

COVID-19 OTC Testing Kit Reimbursement

The Biden-Harris administration announced that effective January 15, 2022 and through the end of the COVID-19 public health emergency, eligible participants and their dependents may get reimbursed from the Plan for up to eight over-the-counter (without a prescription) COVID-19 testing kits per month per person. Following your purchase, reimbursement for tests authorized and approved by the U.S. Food and Drug Administration (FDA) will be considered upon receipt of a completed claim form. The claim form and detailed instructions can be found on the Forms or Health & Welfare pages of our website at www.fvlab.com.

In addition, households can now order up to two sets of four at-home COVID-19 OTC tests from COVIDTests.gov, which will be delivered free of charge to you by the federal government.

Changes in certain defined terms

Certain defined terms have been modernized and the revised terms are shown below:

Hospital

A *hospital* is a legally operated institution that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations and has 24 hour-a-day supervision by a staff of physicians and 24 hour-a-day nursing services by registered graduate nurses. A hospital mainly provides:

- general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic, and major surgical facilities. All of these facilities must be in the hospital or under its control; or
- specialized inpatient medical care and treatment of sick and injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All of these facilities must be in the hospital, under its control, or available under a written agreement with a hospital or with a specialized provider of these facilities; or
- care and treatment of mental, psychoneurotic, and personality disorders, alcoholism, or drug abuse through one or more specialized programs supervised by a physician in regular attendance, has 24 hour-a-day nursing service by registered graduate nurses and meets either of these two tests;
    - it is accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide the type of specialized care; or
    - it is licensed, accredited, or approved by the appropriate agency in the state in which it is located to provide the type of specialized care.

A hospital is not a nursing home, an institution that is used mainly for care in a place of rest, a place for the aged, a place for custodial care, a place for the care or training of mentally or physically handicapped persons, hotel, transitional housing, or similar institution.

Mental Disorder Benefits

A mental disorder treatment is any illness:

- identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- where the psychotherapy or other psychotherapeutic methods are the primary sources of treatment.

Benefits are payable for mental disorder treatment as any other illness. Mental disorder care must be provided by a professional licensed in accordance with state and local laws and performing within the scope of the license. This includes medically necessary

treatment by licensed professionals such as a Medical Doctor (M.D), Doctor of Osteopathy (D.O), Psychologist (Ph.D.), Master of Social Work (M.S.W.), Licensed Professional Counselor, Licensed Clinical Social Worker, Nurse Practitioner, Board Certified Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision for Applied Behavioral Analysis (ABA) therapy.

All inpatient services given by a covered mental health or substance abuse facility or area of a hospital that provides mental health or substance abuse treatment for an illness identified in the DSM are covered by the Plan. Pre-notification of services is required for all inpatient hospital services. The provider should contact Hines & Associates, Inc. as indicated on the Participant's ID card prior to admitting the patient.

Adjustment reactions, developmental delays, and marriage and family counseling are not considered under this Plan to be mental disorder treatment.

Emergency Care

A medical emergency is defined by this Plan as medical care or treatment that is provided after the sudden onset of an emergency medical condition. An emergency medical condition is a medical condition including a mental disorder condition manifesting itself by acute symptoms which are severe, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the lack of immediate medical attention could result in any of the following:

- the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) would be placed in serious jeopardy;
- bodily function would be seriously impaired; or
- there would be serious dysfunction of a bodily organ or part.

Emergency care includes mental disorder treatment when the lack of treatment could reasonably be expected to result in the patient harming themselves and/or other persons.

Emergency Services

Emergency Services with respect to an emergency medical condition include an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition. Also, such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department. It also includes services that are furnished by a Non-Network provider or Non-Network Emergency Facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the Hospital in which such further examination or treatment is furnished).

Independent Freestanding Emergency Department is a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law; and provides any "Emergency Services".

Preferred Provider Organization (PPO) and Non-PPO Providers

Providers with a negotiated service agreement with the Preferred Provider Organization (PPO) is referred to as a PPO Provider or Network Provider or Network facility. A provider without a negotiated service agreement with the PPO is referred to as outside of the PPO Network, Non-PPO Provider or Non-Network Provider.

Qualifying Payment Amount

Qualifying Payment Amount (QPA) is generally the median amount the Plan has contractually agreed to pay Network providers, facilities, or providers of Air Ambulance services for a particular covered service. The amount is updated annually to account for inflation.

Recognized Amount

Recognized Amount with respect to items furnished by a Non-Network provider or Non-Network emergency facility will be determined as the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

CLAIM DECISIONS

The claim decision process has been restated as shown below.

Generally, all claims will be paid as soon as possible after acceptable proof is received. The deadlines differ for the different types of claims as shown below. If circumstances require an extension of time for making a claim determination you will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected. If additional information is needed to process the claim, the initial period will be suspended, and you will be notified of what information is needed. You then have specified time from receipt of the notice to provide the requested information. After a specified time, if sooner, after the information is received, a determination will be made before the end of the initial period, which was suspended.

Health Care Claims.

Post-Service Claims. Generally, an initial determination will be made within 30 days from receipt of the claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 30-day deadline that up to 15 additional days may be needed. If an extension

is needed because the Plan needs additional information to process the claim, the extension notice will specify the information needed. You have 45 days from the time of the notification to supply the additional information. The Plan then has 15 days to make a decision and notify you of the determination.

Pre-Service Claims. Generally, an initial determination will be made within 15 days from receipt of the claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 15-day deadline that up to 15 additional days may be needed. If an extension is needed because the Plan needs additional information to process the claim, the extension notice will specify the information needed. You have 45 days from the time of the notification to supply the additional information. The Plan then has 15 days to make a decision and notify you of the determination.

Urgent Care Claims. Generally, an initial determination will be made within 72 hours from receipt of the claim. If an extension is needed because the Plan needs additional information to process the claim, you will be notified within 24 hours. You have 48 hours from the time of the notification to supply the additional information. The Plan then has 48 hours to make a decision and notify you of the determination.

Concurrent Care Claims. If the concurrent claim is urgent and made 24 hours prior to the end of the already authorized treatment, the Plan will notify you of its decision within 24 hours. If the concurrent claim is not an urgent claim, then the pre-service limits apply.

Loss of Time Claims. An initial determination will be made within 45 days from receipt of the claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 45-day deadline that up to 30 additional days may be needed. If an extension is needed because the Plan needs additional information to process the claim, the extension notice will specify the information needed. You have 45 days to supply the additional information. The Plan will make its decision on the claim and notify you of the determination within 30 days.

Death and Accidental Dismemberment Claims. Generally, written notice on a decision on the claim will be provided within 90 days after the Plan receives the claim. If it is determined that additional time is necessary to make a determination, due to matters beyond the control of the Plan, you will be notified within the initial 90-day deadline that up to 90 additional days may be needed.

If a claim is denied (in whole or in part), you will be notified by the deadlines previously described. The notice will include:

- the specific reason or reasons for the decision;
- reference to the Plan provisions on which the decision was based;
- description of any additional information or material needed to properly process the claim and an explanation of the reason it is needed; and
- a copy of the Plan's claims review procedures and time periods to appeal the claim, plus a statement of your right to bring a lawsuit under ERISA Section 502(a) following the denial of the appeal.
- In addition, for ***health care*** claims, the notice will include a statement that a copy is available to you at no cost, upon request, of:

    - any internal rule, guideline, protocol, or similar criteria if such internal rule, guideline, protocol, or similar criteria was relied on in deciding the claim; or
    - any scientific or clinical judgment if the claim is denied due to medical necessity, experimental treatment, or similar exclusion or limit; or
    - in the case of an urgent care claim, a description of the expedited review process.
- You have the right to request and receive reasonable access to and copies of relevant documents, records and other information free of charge. Relevant documents, records and other information are those that:
    - you have the right to request and were relied upon in making the benefit determination;
    - were submitted, considered or generated in the course of making the benefit determination;
    - demonstrate compliance with the Plan's processes or safeguards; and
    - in the case of health care benefit, constitute a statement of the Plan's policy or guideline regarding the benefit for the diagnosis, whether relied upon or not.
- For ***loss of time*** claims, the denial will include an explanation in a culturally and linguistically appropriate manner for any disagreement with:
    - the findings of the health care and vocational professionals who evaluated or treated you;
    - the views of medical or vocational professionals obtained on the Plan's behalf without regard to whether the advice was relied upon in making the benefit determination;
    - a determination made by the Social Security Administration; and
    - a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

Appealing a Denied Claim

If the claim is denied (in whole or in part) or you disagree with the determination regarding eligibility for benefits or the amount of the benefit, you have the right to have the initial decision reviewed. In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Administrative Office. If a disagreement is not resolved, there is a formal procedure you can follow to have the claim reconsidered. You must follow the appeals procedure before filing a lawsuit under ERISA, the federal law governing employee benefits.

- Generally, you should send a written request for an appeal to the Plan as soon as possible. However, the written appeal must be filed within:
    - 180 days after the notice of denial for ***health care*** or ***loss of time*** claims is received; or
    - 60 days after the notice of denial for ***death*** or ***accidental dismemberment*** claims is received.
- When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Plan authorizing this representative.

A health care professional that has knowledge of the medical condition may act as the authorized representative for health care claims. The written appeal must explain the reasons you disagree with the decision on the claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- submit additional materials, including comments, statements, or documents; and
- request to review all relevant information (free of charge).

Notification of Decision after Appeal

If an appeal is filed on time and follows the required procedures, an independent review of the claim will be made and the Plan will not take into consideration the initial benefit decision. An appropriate fiduciary of the Plan, the Appeal Review Committee, will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on any appeal within five calendar days after the determination is made. The notice will include all legally required information. A determination of the appeal will be made at the next quarterly Appeal Review Committee meeting. However, the determination may be made at the second quarterly meeting if the appeal is received within 30 days of the first quarterly meeting. If special circumstances require an extension of time, a decision may be made at the third quarterly meeting following receipt of your request for review. Although it is not necessary, you (and/or your designated representative) may attend the meeting.

If circumstances require an extension of time for deciding the appeal, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. You must exhaust the appeal process before any legal action can be taken.

- The notification shall include an explanation in a culturally and linguistic appropriate manner the following information:
    - The specific reason or reasons for the adverse determination;
    - Reference to the specific Plan provisions on which the benefit determination is based;
    - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
    - A statement of your right to bring an action under Section 502(a) of ERISA;
    - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- **Post-Service Claims and Loss of Time Claims**

  - A decision in regard to the appeal will be made by the Board of Trustees at the Trustees' meeting following the receipt of the appeal. If the appeal is received within 30 days of a Trustees' meeting, then the decision will be made at the next scheduled Trustees' meeting. If there are special circumstances, then the decision will be made at the third meeting following receipt of the claim. You will be notified of the determination on the claim within five days of the determination.
  - If an adverse benefit determination is received following the final appeal, you have the right to bring a civil action under Section 502(a) of ERISA.
  - In addition, for **loss of time** claims, you are entitled to the following:
    - prior to the date the Plan issues an adverse benefit determination on an appeal of a loss of time benefit claim, the Plan shall provide, free of charge, any new or additional evidence considered and relied upon in making the benefit determination in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date; and
    - prior to the date the Plan can issue an adverse benefit determination on an appeal of loss of time benefit claim based on a new or additional rationale, the Plan shall provide, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

- **Pre-Service and Urgent Care Claims**

  If the appeal involved pre-approval of urgent care, you will be notified of the Trustees' decision about the appeal as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the request for review.
  An urgent care claim is a claim for medical treatment of a condition that would seriously jeopardize your life or subject you to severe pain that cannot be adequately managed without medical care. In the case of other (non-urgent) pre-approvals, you will be notified no later than 30 days after receipt of the request for review.
  If the Trustees do not respond to the appeal within 72 hours for urgent care claims or 30 days for other pre-service claims, the appeal will be considered approved.

- **Death and Accidental Dismemberment Claims.** A decision in regard to the appeal will be made within 60 days following the receipt of the appeal.

- **Medical Judgments**

  If the claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional who:
  - has appropriate training and experience in the field of medicine involved in the medical judgment; and
  - was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

  You have the right to be advised of the identity, upon request, of any medical experts consulted in making a determination of the appeal.

- **External Review (effective June 1, 2022)**

  You may request an external appeal review after an initial Claim Denial and subsequent internal review appeal denial to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act. The process for an external review is as follows:

  - Request for External Review will be allowed if you request an external appeal within four months after receipt of notice of claim denial or appeal denial. An immediate external review must also be allowed if the Plan has failed to adhere to the appeals regulations unless the violation was:
    - de minimis;
    - non-prejudicial;
    - attributable to good cause or matters beyond the Plan's control;
    - in the context of an ongoing good-faith exchange of information; and
    - not reflective of a pattern or practice of non-compliance.

  If the Plan asserts an exception, you are entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the external reviewer rejects your request for immediate review on the basis that the Plan has met the five-element exception, you are permitted to resubmit and pursue an internal appeal.

  - The Preliminary Review of the external appeal must be completed within five business days after receipt of request to determine whether:
    - you were covered under the Plan at the time the health care item or service was provided;
    - the initial claim denial or internal review claim denial did not relate to your failure to meet eligibility requirements for eligibility under the Plan;
    - you have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under the regulations; and
    - you have provided all the information and forms required to process an External Review.

    Within one business day after completion of preliminary review, the Plan must issue notification in writing to you. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (call toll-free (866) 444-EBSA (3272)). If the request is not

complete, such notification must describe the information and materials needed to make the request complete and the Plan must allow you to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification, whichever is later. For an urgent care issue, the preliminary review must be done immediately and you must be notified of the decision immediately.

- Referral to Independent Review Organization (IRO)

  The Plan will utilize an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and ensure independence. The IRO process may not impose any costs, including filing fees, on you requesting the external review.

  Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment. For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.

- Implementation of Reversal

  Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Statement of Grandfathered Plan Status: The Fox Valley Laborers Health and Welfare Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA 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 PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections 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 Plan Administrator at (847) 742-0900. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans

If you have any questions reading this notice, please contact the Administrative Office.

SUMMARY OF MATERIAL MODIFICATIONS –April 2022 – EIN: 36-6219639 – PLAN NO. 501. This announcement contains highlights of certain features of the Fox Valley Laborers Health and Welfare Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the language contained in this announcement and the documents that establish the Plan, the document language will govern and control. The Trustees reserve the right to amend, modify or terminate the Plan at any time. Receipt of this announcement does not guarantee eligibility.

FOX VALLEY & VICINITY LABORERS

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-696-6775.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-696-6775
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-696-6775。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-696-6775.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-696-6775.
Greek	ΠΡΟΣΟΧΗ: Εάν μιλάτε αγγλικά, οι υπηρεσίες γραμματείας, δωρεάν, είναι διαθέσιμες σε εσάς. Καλέστε 1-877-696-6775.
Gujarati	સાવધાન: જો તમે ઇંગલિશ બોલતા હો, ભાષા સહાય સેવાઓ, નિઃશુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-877-696-6775 પર કૉલ કરો
Hindi	सावधानी: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएं निःशुल्क, आपके लिए उपलब्ध हैं। 1-877-696-6775 पर कॉल करें।
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-696-6775.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-696-6775.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-696-6775.
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-696-6775.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-696-6775.
Urdu	انتباہ: اگر آپ انگلش بولتے ہیں تو، زبان کی مدد کی خدمات، مفت چارج، آپ کے لئے دستیاب ہیں۔ 1-877-696-6775 کو کال کریں۔
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-696-6775.

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