FOX VALLEY & VICINITY LABORERS

HEALTH AND WELFARE AND PENSION FUNDS

DATE: November 1, 2025

TO: Eligible Participants and Dependents

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. This letter contains information on improvements, and changes to the benefits provided by your Health and Welfare Plan.

REMINDER - IMPORTANT NOTICE - Changes to Out-of-Network Coverage

Effective January 1, 2026, benefit coverage for physicians and facilities outside the BlueCross BlueShield (BCBS) preferred provider network will be changing, as follows:

- After deductible, Plan pays 70% and you pay 30% of covered allowable charges
- Annual out-of-pocket maximum amount will not apply to non-PPO providers; therefore, the Plan will not ever pay these charges in full and you will always have an out-of-pocket expense
- Allowable charges will be considered at 150% of Medicare allowable limits

Services covered under the No Surprises Act such as Non-Network Emergency Services, Non-Network Providers at Network Facilities, and Non-Network Air Ambulance Providers are not impacted by this change.

When seeking treatment from a provider or facility outside the PPO network, in-network discounts are not applicable. This means that you will be paying more out of pocket for your out-of-network care. Benefit coverage is more favorable to you and your out-of-pocket expenses are reduced when your treatment is provided by an in-network provider. Please consider finding a doctor or hospital in the BCBS network by calling (800) 810-2583 or by searching the online tool at www.bcbsil.com.

BlueCross BlueShield Identification Cards

Watch your mailbox for new ID cards from BlueCross BlueShield. The backside of the card reflects the change that out-of-pocket amounts apply to the annual maximum for in-network providers only and does not apply for out-of-network/non-PPO providers. Be sure to replace your current card with the new card!

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Reminder…Medicare eligible retirees and/or spouses should be presenting the gray paper identification card (that is provided quarterly by the Fund Office) to your providers. Please discontinue using the BlueCross BlueShield ID card if Medicare eligible.

Emergency Ground Ambulance
Effective January 1, 2026, the Plan will pay 90% and you pay 10% of the allowable charge for non-network emergency ground ambulance services. The allowable charge for emergency ground ambulance fees will be set at the pricing provided by the network vendor even if the ambulance service is out-of-network. Your portion of the allowable charge will count towards the annual out-of-pocket maximum.

Gene and Cellular Therapy:
Effective January 1, 2026, pre-authorized, FDA approved gene and cellular therapy including targeted cancer gene therapy that is not experimental or investigational must be rendered by an in-network provider. Services performed by an out-of-network provider or services that are not pre-authorized will not be covered. Pre-authorization for gene and cellular therapy is required by calling Hines & Associates at (800) 323-3454 prior to obtaining care.

Specialty Medications:
Effective January 1, 2026, individuals taking certain specialty medications under the prescription drug benefit will be required to enroll in PrudentRx and follow the required procedures. This manufacturer copay assistance program offers savings on eligible specialty medications with a $0 out-of-pocket cost for you. If the covered specialty drug is not on the PrudentRx program drug list, there will be no change to your copay of $8.00 for a generic or $15 for a brand name drug or medication.

If you do not enroll in the cost savings program, a flat 30% copay for the specialty medication will apply, and the 30% copay will not count towards the $3,000 per person prescription drug calendar year out-of-pocket maximum.

You will be contacted by Prudent Rx to assist in the enrollment if you or any eligible dependents are currently taking specialty medications that qualify for this cost saving benefit.

See the enclosed updated Summary of Benefits and Coverage for the coverage period of January 1, 2026 through May 31, 2026.

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

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	В Н И М А Н И Е: 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، خدمات، چارج مفت، آپ کے لئے۔ 1-877-696-6775 کو کال کریں۔ اب دستیاب ہیں۔
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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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-828-0900 or visit us at www.fvlab.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-866-828-0900 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150** per person / **$400** family Carry forward of October, November and/or December expenses satisfying the deductible to the next calendar year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, accidental injury and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care services without cost sharing and before you meet your deductible. See a list of covered preventive care services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Dental: **$50** per person. Doesn't apply to preventive dental care. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: **$1,500** per person, plus $150 deductible ($400 family) network providers only. Prescription Drug: **$3,000** per person	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Out-of-network provider charges and care the plan doesn't cover	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	For accidental injury, Plan pays 100% of covered expenses for office visits, physician services, and hospital charges incurred within 48 hours of the injury, up to $750 per person per calendar year (deductible waived).
	Specialist visit	10% coinsurance	30% coinsurance	Acupuncture is covered for individuals over age five for treatment of the back, neck, spine, and vertebra, for conditions due to subluxation, strains, sprains, and nerve root problems. The care must be provided by a physician. Chiropractic care rendered by a licensed chiropractor for individuals over age five for treatment of dysfunction in joints and muscles that may be associated with neurological or mechanical dysfunction of the spinal joint and surrounding tissue and appendicular skeleton for up to 26 visits per calendar year with an extension of up to an additional 26 medically necessary visits after medical review is covered.
	Preventive care/screening/ immunization	No charge (deductible does not apply)	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None

*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	**Retail** - $8 copayment/prescription; **Mail Order or Contracted Retail Pharmacy** - $15 copayment/prescription	**Retail** – 50% coinsurance after $8 copayment/ prescription; if no in-network pharmacy available within zip code, 20% coinsurance after $8 copayment/ prescription. File claim with Fund Office	Covers up to 30-day supply (retail); 90-day supply (mail order or contracted retail pharmacy). 90-day supply is required for maintenance medications after two 30-day retail pharmacy fills. Copayments count towards the prescription drug out-of-pocket limit f medical out-of-pocket limit. Your specialty drug copayment does not count towards the prescription drug out-of-pocket limit if the drug is on the PrudentRx drug list and you don't enroll in the program. Certain preventive medications including certain contraceptives and immunizations are covered at no charge at a network pharmacy. Certain prescriptions are not covered, including prescriptions that are not on the pharmacy network formulary list. Certain drugs require prior authorization. If you don't get preauthorization, benefits could be reduced where plan pays nothing. Clinical management programs apply to certain prescription drugs, including specialty medications. Specialty drugs must be dispensed by the CVS/Caremark specialty pharmacy.
	Preferred brand drugs	**Retail** - $15 copayment/prescription; **Mail Order or Contracted Retail Pharmacy** - $30 copayment/prescription; And, if generic is available copayment is $15 or $30 plus the cost differential between the brand name and generic.	**Retail** – 50% coinsurance after $15 copayment/ prescription; if no in-network pharmacy available within zip code, 20% coinsurance after $15 copayment/ prescription. File claim with Fund Office	
	Non-preferred brand drugs	Same as preferred	Same as preferred	
	Specialty drugs	Same as preferred if drug is not on the PrudentRx drug list; if the drug is on the PrudentRx drug list and member enrolls - $0 copayment/prescription; if not enrolled - 30% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Out-of-network ancillary services at in-network facility are covered at in-network cost sharing.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	

*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	If accidental injury care received within 48 hours of the injury, deductible does not apply and coinsurance does not apply to the first $750 of charges.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Air transportation is covered only if due to inaccessibility by ground transport or ground transport would be detrimental to the patient's health status.
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Private rooms are only covered if it is determined to be medically necessary; weekend admission (Friday or Saturday) is covered only if treatment or surgery is provided within 24 hours of hospital admission. Post stabilization services provided at an out-of-network facility after an emergency admission are covered at 10% coinsurance. Out-of-network ancillary services at in-network facility are covered at in-network cost sharing.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Post stabilization services provided at an out-of-network facility after an emergency admission are covered at 10% coinsurance. Out-of-network ancillary services at in-network facility are covered at in-network cost sharing.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Covered for care within seven days following an inpatient hospital stay for the same or related condition
	Rehabilitation services	10% coinsurance	30% coinsurance	Physical, speech and occupational therapy for

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				short-term therapy for physical treatment to improve the status of a physical disability and ordered by a physician is covered for a continuous course of treatment for up to 26 weeks (short-term) for a specific condition/diagnosis when performed by a registered physical therapist or chiropractor, registered speech therapist, or registered or licensed occupational therapist. An extension of benefits recommended by the physician may be approved after medical review in certain specific circumstances. Refer to the plan document for the rules and limitations.
	Habilitation services	10% coinsurance	30% coinsurance	Physical, speech and occupational therapy is covered for dependents with a congenital disability.
	Skilled nursing care	10% coinsurance	30% coinsurance	Must be provided by a licensed registered or practical nurse and prescribed by a physician.
	Durable medical equipment	10% coinsurance. Covers the rental of durable medical equipment not to exceed a reasonable purchase price	30% coinsurance. Covers the rental of durable medical equipment not to exceed a reasonable purchase price.	Purchase of medically necessary equipment and cost of maintenance agreements are covered only when the plan determines that it is cost effective. One pair of medically necessary custom orthotic devices prescribed by a physician or podiatrist is covered in a 12-month period.
	Hospice services	10% coinsurance	30% coinsurance	Coverage limited to an individual who is diagnosed as terminally ill with 6 months or less to live by a certified physician.
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply)	No charge (deductible does not apply)	Once every calendar year
	Children's glasses	No charge	No charge	$300 calendar year limit.
	Children's dental check-up	Preventive Care - No charge (deductible does not apply)	Preventive Care - No charge (deductible does not apply)	Dental x-rays fall under General Care. Annual limit for children: up to age 18 – no annual limit

*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		General Care – 15% coinsurance (dental deductible applies)	General Care – 15% coinsurance (dental deductible applies)	age 18 and over – $2,500 limit

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery (limited exceptions)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs and weight loss drugs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery (authorization required)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment (excluding children)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (transplant care)
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: the Fund Administrative Office at 1-866-828-0900 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-828-0900.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, call 1-866-828-0900. Balance billing does not apply to out-of-network emergency room care, air ambulance or treatment from ancillary providers at certain in-network facilities. A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$150
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,420**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$150
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other (Rx) copayments	$8/$15/Rx

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$670**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

The plan's overall deductible	$150
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460**

A Family Supplemental Benefit based on years of service is available to reimburse certain medically necessary expenses that are not covered under the plan, other than deductible or out–of–pocket limit expenses

The **plan** would be responsible for the other costs of these EXAMPLE covered services.