***Office Location:*** 4208 W. Partridge Way, Unit 3 • Peoria • IL 61615-2467

***Toll Free:*** 1-866-692-0860 ***Phone:*** 309-692-0860 ***Fax:*** 309-692-0862

**SUMMARY OF MATERIAL MODIFICATIONS**

Date: November 2022

To: Plan Participants and Their Eligible Dependents Enrolled in the North Central Illinois Laborers' Health and Welfare Fund

From: The Board of Trustees

The Trustees of the North Central Illinois Laborers' Health and Welfare Fund (the "Fund") is notifying you of important changes being made to your benefits. This Summary of Material Modifications (SMM) provides details about the Plan's coverage for services provided under the No Surprises Act. Please read this SMM in its entirety to make sure you understand your enhanced health care coverage.

## NO SURPRISES ACT SERVICES

### Coverage of Emergency Services and Certain Non-Emergency Services Received at In-Network Facilities

Effective July 1, 2022, the Plan will comply with the federal No Surprises Act. An explanation of your rights under the No Surprises Act is attached to this Summary of Material Modifications (SMM). The No Surprises Act requires that the Plan be amended as follows:

1. The Plan will cover Emergency Services provided at an out-of-network facility or by an out-of-network health care provider in the same manner as in-network Emergency Services. Air ambulance services provided by an out-of-network provider will also be covered in the same manner as in-network Air Ambulance services. This means the following with respect to how Emergency Services and air ambulance services are covered:
    a. You will pay the same cost-sharing whether you receive covered Emergency Services from an out-of-network facility or provider or an in-network facility or provider. In general, you cannot be balance billed for covered Emergency Services. Your cost-sharing will be based on the Recognized Amount payable for these services.
    b. Any cost-sharing payments you make with respect to out-of-network Emergency Services will count toward your in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider.
    c. The Plan will not impose prior authorization requirements for Emergency Services and will not impose more restrictive administrative requirements on out-of-network Emergency Services than in-network ones.
2. If you receive non-emergency items or services that are otherwise covered by the Plan from an out-of-network provider who is working at an in-network facility, those non-emergency items or services will be covered by the Plan as follows:

a. The non-emergency items or services received from an out-of-network provider working at an in-network facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider,

b. In general, you cannot be balance billed for these non-emergency items or services. Your cost-sharing will be based on the Recognized Amount payable for these services.

c. Any cost-sharing payments you make with respect to covered non-emergency services will count toward your in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider.

3. In certain circumstances, you can be billed by an out-of-network provider who works at an in-network facility. This can occur if you are notified by the out-of-network provider that they do not participate with the Plan. The provider must give you a notice stating certain information required by federal law, including that the provider is an out-of-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 in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed. If you give informed consent to be treated by the out-of-network provider, then the Plan will pay for these services at the out-of-network rate, and the provider can bill you for the balance directly. This rule does not apply to services provided by hospital-based providers, such as anesthesiologists and radiologists.

4. Emergency Medical Condition means 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.

5. Emergency Services means the following:

   a. 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

   b. Within the capabilities of the staff and facilities available at the hospital or the 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).

   c. Emergency Services include post stabilization services (services 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 provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation.

6. The Recognized Amount on which your cost sharing amount is based will be the lessor of billed charges from the provider or the Qualifying Payment Amount, which means the Plan's median in-network rate.

**Continuing Coverage with a Provider Who Leaves the Plan's Network**

Effective July 1, 2022, if you are a Continuing Care Patient and the Plan's contract with your in-network provider or facility terminates, 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:

1. 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
2. Allow you ninety (90) days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.
3. You are a Continuing Care Patient with respect to a provider or facility if you are:
    a. undergoing a course of treatment for a serious and complex condition from the provider or facility;
    b. undergoing a course of institutional or inpatient care from the provider or facility;
    c. scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
    d. pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
    e. determined to be terminally ill and receiving treatment for such illness from such provider or facility.

## UPDATED SCHEDULE OF BENEFITS FOR BLUECROSS BLUESHIELD OF ILLINOIS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - EFFECTIVE JULY 1, 2022

The Schedule of Benefits for the BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan has been updated for the No Surprises Act.

| Medical Benefits | In-Network (Illinois Providers Only) | Out-of-Network |
|---|---|---|
| Calendar Year Deductible[1] - Individual<br>- Family | $500<br>$1,500 | $1,000<br>$4,500 |
| Out-of-Pocket Maximum - Individual<br>- Family | $2,500<br>$7,500 | Unlimited<br>Unlimited |
| Maximum Medical and Prescription Drug Calendar Year Benefit | Unlimited | |
| Penalty for Failure to Preauthorize Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care, and Transplant Benefits | $250 reduction in benefits | $250 reduction in benefits<br>NOTE: the Plan does not cover out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care |
| Hospital Benefits (inpatient and outpatient)<br>*Preauthorization of out-of-network Inpatient Hospital Services Required* | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act<br>Preauthorization not required in the case of an Emergency Medical Condition covered by the No Surprises Act |
| Outpatient Surgical Procedures[1]<br>*Preauthorization Required* | 80%; no deductible required | 50%; no deductible required, except 80%; no deductible required in the case of an Emergency Medical Condition or a Non-Emergency |

| | | |
|---|---|---|
| | | Medical Condition covered by the No Surprises Act |
| Primary Care Doctor's Office Visits | $20 copay | 50% |
| Specialist Office Visit | $50 copay | 50% |
| X-Rays and Labs (including Pre-Admission Testing) | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Wellness, Preventive, Well Child, Well Baby Care[1] | 100%; no deductible required | Not Covered |
| Maternity Services | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Urgent Care | 80% | 80% |
| Emergency Services | $200 copay | $200 copay |
| Ambulance Service | 80% | 80% |
| *Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate* | | |
| Rehabilitation Services/Habilitation Services/Skilled Nursing Facility<br>Inpatient - Coinsurance<br>- Calendar Year Maximum<br><br>Outpatient - Coinsurance<br>- Calendar Year Maximum | <br><br>80% if Medically Necessary<br>60 days per person<br><br>80% if Medically Necessary<br>60 visits per person (combined with out-of- network) | Out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care services are not covered, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act<br><br>50% if Medically Necessary for outpatient services, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act<br><br>60 visits per person (combined with in-network) |
| *Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services* | | |
| Mental Health Services/Substance Abuse<br>Inpatient - Coinsurance<br>Outpatient - Copay/Coinsurance<br><br>*Preauthorization of Out-of-Network Inpatient Services Required – Call Medical Cost Management (MCM)*<br><br>• *For a list of in-network providers, contact BCBSIL*<br>• *For up to 6 free visits, contact the MAP provider listed on page 3* | <br>80%<br>$20 copay office visit;<br><br>no deductible required (outpatient only) | Out-of-network Residential Treatment, Skilled Nursing or Inpatient Habilitation care services are not covered, , then paid at 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act<br><br>50% if Medically Necessary for outpatient services, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |

| | | |
|---|---|---|
| | | no deductible required (outpatient only) |
| Additional Surgical Opinion[1] | 80%; no deductible required | 50%; no deductible required, except 80%; no deductible required in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Durable Medical Equipment/Prosthetic Devices | 80% (additional limitations apply) | 50% (additional limitations apply) |
| Spinal Manipulation (Chiropractic or Medical)<br>Calendar Year Maximum<br>*Acupuncture included when Physician prescribed* | $15 copay per visit<br>60 treatments up to $1,000 (combined with out-of- network) | 50%<br>60 treatments up to $1,000 (combined with in-network) |
| Home Health Care - Coinsurance<br>- Calendar Year Maximum | 80%<br>40 visits (combined with out-of-network) | 50%<br>40 visits (combined with in-network) |
| Podiatry Services<br>Orthotic Calendar Year Maximum | 80%<br>$500 (combined with out-of-network) | 50%<br>$500 (combined with in-network) |
| Other Covered Services, Radiation Therapy, Hospice Care and Gene Therapy<br>Preauthorization Required for Inpatient Hospice Care and Gene Therapy | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Treatment of Temporomandibular Joint (TMJ)<br>Preparatory Work Lifetime Maximum<br><br>Surgery Lifetime Maximum | 80%<br>$1,000 (combined with out-of-network)<br>$2,000 (combined with out-of-network) | 50%<br>$1,000 (combined with in-network)<br><br>$2,000 (combined with in-network) |
| Smoking Cessation Benefits | 80% | 50% |

| **Sav-Rx Prescription Drug Benefit** | ***Prescription drug benefits are only covered when filled at a participating pharmacy.*** |
|---|---|
| Out-of-Pocket Maximum - Individual<br>- Family | $4,100<br>$5,700 |
| Retail Pharmacy<br>Generic Medication<br>Preferred Brand Name Medication<br>Non-Preferred Brand Name Medication<br>Specialty Medication | For up to a 34-day supply, you pay:<br>10% (minimum $10, maximum $20)<br>20% (minimum $20, maximum $50)<br>30% (minimum $35, maximum $125)<br>20% (minimum $20, maximum $50) |
| Mail Order Pharmacy/Retail Maintenance Program<br>Generic Medication<br>Preferred Brand Name Medication<br>Non-Preferred Brand Name Medication<br>Specialty Medication | For up to a 90-day supply, you pay:<br>10% (minimum $20, maximum $40)<br>20% (minimum $50, maximum $100)<br>30% (minimum $100, maximum $250)<br>20% (minimum $50, maximum $100) |
| **Delta Dental of Illinois Dental Benefits 2** | |
| Calendar Year Deductible (*applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*) | $50 Individual/ $100 Family |
| Dental Benefits Calendar Year Maximum | $1,500 [3] |

| Type of Dental Services | Delta Dental PPO Network[2] | Delta Dental Premier Network[2] | Out-of-Network[2] |
|---|---|---|---|
| Preventive/Diagnostic Care Services<br>Coinsurance paid by the Plan | 100% of reduced fee (deductible applies) | 100% of maximum plan allowance (deductible applies) | 80% of maximum plan allowance (deductible applies) |
| Primary (Basic) Care Services<br>Coinsurance paid by the Plan | 80% of reduced fee (deductible applies) | 80% of maximum plan allowance (deductible applies) | 80% of maximum plan allowance (deductible applies) |
| Major Care Services<br>Coinsurance paid by the Plan | 80% of reduced fee (deductible applies) | 80% of maximum plan allowance (deductible applies) | 80% of maximum plan allowance (deductible applies) |
| Orthodontia Benefits (only for eligible Dependent children under age 19) - Coinsurance paid by the Plan | 50% of reduced fee | 50% of maximum plan allowance | 50% of maximum plan allowance |
| **Vision Benefits** | **Administered by Professional Benefit Administrators, Inc.** | | |
| Covered Services | $250 per person per calendar year3 | | |
| **Hearing Benefits** | **Administered by Professional Benefit Administrators, Inc.** | | |
| Hearing Benefits Lifetime Maximum | $5,000[4] | | |

1 The deductible applies to all covered benefits, except that you do not need to satisfy the deductible and it does not apply to surgical procedures performed on the day of surgery, second surgical opinion benefits, or outpatient mental health, in-network wellness, preventive, well-child, and well-baby care services.

2 For expenses incurred from a Delta Dental PPO Network Dentist or a Delta Dental Premier Dentist, you will not be "balance billed" for charges exceeding Delta Dental's allowed PPO fees or Delta Dental's maximum plan allowances, as applicable. *For expenses incurred from an Out-of-Network dentist, you are responsible for charges exceeding Delta Dental's maximum plan allowances.*

3 The maximums do not apply to children under the age of 19 for preventive dental, orthodontia, and vision exams.

4 The maximum does not apply toward hearing exams.

Payments made by the Plan will be made only if the expenses are Medically Necessary and Allowable. Benefits are subject to other limitations contained in the Summary Plan Description. Calendar Year limitations and maximums are calculated based on the date you incur the claim, which is the date service is rendered, and not the date the claim is paid. See the Summary Plan Description for information about additional benefits that are applicable only to Eligibility A Employees

## UPDATED SCHEDULE OF BENEFITS FOR CIGNA PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - EFFECTIVE JULY 1, 2022

The Schedule of Benefits for the CIGNA Preferred Provider Organization (PPO) Plan has been updated for the No Surprises Act.

| Medical Benefits | | In-Network (Illinois Providers Only) | Out-of-Network |
|---|---|---|---|
| Calendar Year Deductible[1] | - Individual<br>- Family | $500<br>$1,500 | $1,000<br>$4,500 |
| Out-of-Pocket Maximum | - Individual<br>- Family | $2,500<br>$7,500 | Unlimited<br>Unlimited |
| Maximum Medical and Prescription Drug Calendar Year Benefit | | Unlimited | |
| Penalty for Failure to Preauthorize Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care and Transplant Benefits | | $250 reduction in benefits | $250 reduction in benefits<br>NOTE: the Plan does not cover out-of-network Residential Treatment, Skilled Nursing or Inpatient |

| | | |
|---|---|---|
| | | Rehabilitation or Inpatient Habilitation care |
| Hospital Benefits (inpatient and outpatient)<br>*Preauthorization of Out-of-Network Inpatient Hospital Services Required* | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act<br><br>Preauthorization not required in the case of an Emergency Medical Condition covered by the No Surprises Act |
| Outpatient Surgical Procedures[1]<br>*Preauthorization Required* | 80%; no deductible required | 50%; no deductible required, except 80%; no deductible required in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Primary Care Doctor's Office Visits | $20 copay | 50% |
| Specialist Office Visit | $50 copay | 50% |
| X-Rays and Labs (including Pre-Admission Testing) | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Wellness, Preventive, Well Child, Well Baby Care1 | 100%; no deductible required | Not Covered |
| Maternity Services | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Urgent Care | 80% | 80% |
| Emergency Services | $200 copay | $200 copay |
| Ambulance Service | 80% | 80% |
| *Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate* | | |
| Rehabilitation Services/Habilitation Services/Skilled Nursing Facility<br>Inpatient - Coinsurance<br>- Calendar Year Maximum<br><br>Outpatient - Coinsurance<br>- Calendar Year Maximum | <br><br>80%<br>60 days per person<br><br>80%<br>60 visits per person (combined with out-of- network) | Out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care services are not covered, except that unless an Emergency Medical Condition is covered as an Emergency Service, then paid at 50%<br><br>50% if Medically Necessary for outpatient services, except that an Emergency Medical Condition is covered as an Emergency Service<br><br>60 visits per person (combined with in- network) |
| *Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services* | | |
| Mental Health Services/Substance Abuse<br>Inpatient - Coinsurance<br>Outpatient - Copay/Coinsurance | <br>80%<br>$20 copay office visit | <br>Out-of-network Residential Treatment, Skilled Nursing or Inpatient Habilitation care services are not covered, except that an Emergency |

| | | |
|---|---|---|
| *Preauthorization of Out-of-Network Inpatient Services Required - Call Professional Benefit Administrators (PBA)*<br>• *For a list of in-network providers, contact PBA*<br>• *For up to 6 free visits, contact the MAP provider listed on page3* | no deductible required (outpatient only) | Medical Condition is treated as an Emergency Service, then paid at 50%<br>50% if Medically Necessary for outpatient services, except that an Emergency Medical Condition is covered as an Emergency Service no deductible required (outpatient only) |
| Additional Surgical Opinion[1] | 80%; no deductible required | 50%; no deductible required, except 80%; no deductible required in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Durable Medical Equipment/Prosthetic Devices | 80% (additional limitations apply) | 50% (additional limitations apply) |
| Spinal Manipulation (Chiropractic or Medical)<br>Calendar Year Maximum<br>*Acupuncture included when Physician prescribed* | $15 copay per visit<br>60 treatments up to $1,000 (combined with out-of- network) | 50%<br>60 treatments up to $1,000 (combined with in-network) |
| Home Health Care<br>- Coinsurance<br>- Calendar Year Maximum | 80%<br>40 visits (combined with out-of-network) | 50%<br>40 visits (combined with in-network) |
| Podiatry Services<br>Orthotic Calendar Year Maximum | 80%<br>$500 (combined with out-of-network) | 50%<br>$500 (combined with in-network) |
| Other Covered Services, Radiation Therapy, Hospice Care and Gene Therapy<br>*Preauthorization Required for Inpatient Hospice Care and Gene Therapy* | 80% | 50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act |
| Treatment of Temporomandibular Joint (TMJ)<br>Preparatory Work Lifetime Maximum<br><br>Surgery Lifetime Maximum | 80%<br>$1,000 (combined with out-of-network)<br>$2,000 (combined with out-of-network) | 50%<br>$1,000 (combined with in-network)<br><br>$2,000 (combined with in-network) |
| Smoking Cessation Benefits | 80% | 50% |

| **Sav-Rx Prescription Drug Benefit** | ***Prescription drug benefits are only covered when filled at a participating pharmacy.*** |
|---|---|
| Out-of-Pocket Maximum - Individual<br>- Family | $4,100<br>$5,700 |
| Retail Pharmacy<br>Generic Medication<br>Preferred Brand Name Medication<br>Non-Preferred Brand Name Medication<br>Specialty Medication | For up to a 34-day supply, you pay:<br>10% (minimum $10, maximum $20)<br>20% (minimum $20, maximum $50)<br>30% (minimum $35, maximum $125)<br>20% (minimum $20, maximum $50) |
| Mail Order Pharmacy/Retail Maintenance Program<br>Generic Medication<br>Preferred Brand Name Medication<br>Non-Preferred Brand Name Medication<br>Specialty Medication | For up to a 90-day supply, you pay:<br>10% (minimum $20, maximum $40)<br>20% (minimum $50, maximum $100)<br>30% (minimum $100, maximum $250)<br>20% (minimum $50, maximum $100) |

| **Delta Dental of Illinois Dental Benefits [2]** | | | |
|---|---|---|---|
| Calendar Year Deductible (*applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*) | $50 Individual/ $100 Family | | |
| Dental Benefits Calendar Year Maximum | $1,500 [3] | | |
| Type of Dental Services | **Delta Dental PPO Network2** | **Delta Dental Premier Network2** | **Out-of-Network2** |
| Preventive/Diagnostic Care Services<br>Coinsurance paid by the Plan | 100% of reduced fee (deductible applies) | 100% of maximum plan allowance (deductible applies) | 80% of maximum plan allowance (deductible applies) |
| Primary (Basic) Care Services<br>Coinsurance paid by the Plan | 80% of reduced fee (deductible applies) | 80% of maximum plan allowance (deductible applies) | 80% of maximum plan allowance (deductible applies) |
| Major Care Services<br>Coinsurance paid by the Plan | 80% of reduced fee (deductible applies) | 80% of maximum plan allowance (deductible applies) | 80% of maximum plan allowance (deductible applies) |
| Orthodontia Benefits (only for eligible Dependent children under age 19) –<br>Coinsurance paid by the Plan | 50% of reduced fee | 50% of maximum plan allowance | 50% of maximum plan allowance |
| **Vision Benefits** | **Administered by Professional Benefit Administrators, Inc.** | | |
| Covered Services | $250 per person per calendar year[3] | | |
| **Hearing Benefits** | **Administered by Professional Benefit Administrators, Inc.** | | |
| Hearing Benefits Lifetime Maximum | $5,000[4] | | |

1 The deductible applies to all covered benefits, except that you do not need to satisfy the deductible and it does not apply to surgical procedures performed on the day of surgery, second surgical opinion benefits, or outpatient mental health, in-network wellness, preventive, well-child, and well-baby care services.

2 For expenses incurred from a Delta Dental PPO Network Dentist or a Delta Dental Premier Dentist, you will not be "balance billed" for charges exceeding Delta Dental's allowed PPO fees or Delta Dental's maximum plan allowances, as applicable. ***For expenses incurred from an Out-of-Network dentist, you are responsible for charges exceeding Delta Dental's maximum plan allowances.***

3 The maximums do not apply to children under the age of 19 for preventive dental, orthodontia, and vision exams.

4 The maximum does not apply toward hearing exams.

Payments made by the Plan will be made only if the expenses are Medically Necessary and Allowable. Benefits are subject to other limitations contained in the Summary Plan Description. Calendar Year limitations and maximums are calculated based on the date you incur the claim, which is the date service is rendered, and not the date the claim is paid. See the Summary Plan Description for information about additional benefits that are applicable only to Eligibility A Employees**.**

## FINAL NOTE

Please share this SMM with your family members and store it with your Summary Plan Description (SPD)/Plan Document booklet for easy reference.

If you have any questions regarding the benefits discussed in this SMM or your Plan benefits in general, do not hesitate to contact the Fund Office at (309) 692-0860 or (866) 692-0860.

This Summary of Material Modifications provides only highlights of recent changes to the North Central Illinois Laborers' Health and Welfare Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify or terminate the Plan at any time.

## Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing

### What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"**Surprise billing**" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

### You are protected from balance billing for:

#### Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

#### Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

**When balance billing isn't allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, you may contact the federal agencies at 1-800-985-3059. Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.