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February 2018

Dear Participant:

As Trustees of the North Central Illinois Laborers' Health and Welfare Fund (the "Fund" or "Plan"), we keep informed of legislative changes and health care trends to remain in compliance and ensure your benefits are cost-effective. This Summary of Material Modification (SMM) informs you of certain Fund procedures relative to Loss of Time Benefit claims filed on and after April 1, 2018. It also includes how the Fund's manner of reimbursement of air ambulance services will change effective May 1, 2018. **Please read this SMM in its entirety so that you understand how these changes may affect you.**

Claims and Appeals Procedure Changes

The following identifies procedures if you file a Loss of Time Benefit claim on and after April 1, 2018.

Denial or Adverse Benefit Determination of a Loss of Time Benefit Claim

Due to new legislation, if you file a claim for Loss of Time Benefits on and after April 1, 2018 and your claim is denied, in whole or in part, you will be sent a notice of the initial adverse benefit determination of your claim. The notice will provide all of the following:

- The specific reason or reasons your claim was denied.
- A reference to the specific Plan provisions on which the denial was based.
- A description of any additional information you need to submit in support of your claim.
- An explanation of why the additional information is needed.
- An explanation of the Plan's claim review procedures and applicable time limits.
- The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination; or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist.
- An explanation of the clinical or scientific judgment for the determination, applying the terms of the Plan to your medical circumstances, if the adverse benefit determination was based on medical necessity or other similar exclusions, or a statement that such explanation will be provided free of charge upon request.
- A discussion of the decision, including an explanation of the basis for disagreeing with the views of:
    - Any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable);
    - Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your (or a claimant's) denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and
    - Any disability determination made by the Social Security Administration (if applicable).

- A statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records, and other information to your claim for benefits.
- A statement of your right to present evidence and testimony in support of your claim during the appeal/review process.
- A statement that before the Plan can issue an adverse benefit determination on review of a disability claim, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The 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 under the Plan to give you a reasonable opportunity to respond prior to that date.
- A statement that before the Plan can issue an adverse benefit determination on review of a disability claim based on a new or additional rationale, the Plan will provide you, 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 under the Plan to give you a reasonable opportunity to respond prior to that date.
- A statement of your rights, under the Employee Retirement Income Security Act of 1974 (ERISA), to bring a civil action.

If applicable, the notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

Right to Appeal a Denial of a Loss of Time Benefit Claim

If any claim you file for Loss of Time Benefits on or after April 1, 2018 is denied by the Plan, or if there is any adverse benefit determination with regard to your claim, you have the right to a full and fair review of that claim. You must file your appeal directly to the Fund Office in writing. Your written application for an appeal must include the specific reasons you feel the denial was improper. The Fund Office will prepare your appeal file for review by the Executive Board and decision by the full Board of Trustees.

The decision on any review of your Loss of Time Benefit claim will be given to you in writing. The notice of a denial of a claim on review will:

- State the specific reason(s) for the denial.
- Reference the specific Plan provisions on which the benefit determination is based.
- Provide a statement that you have the right to request a free copy of all documents, records and information relevant to your appeal.
- Provide the specific internal rule, guideline, protocol, standard, or other similar criterion, if any, relied upon in making the determination or alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria does not exist.
- Include an explanation of the scientific or clinical judgment for the determination, if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation, or a statement that such explanation will be provided free of charge upon request.
- Include an explanation for disagreeing with the views of any:
  - Health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable);
  - Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your (or a claimant's) denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and
  - Disability determination made by the Social Security Administration (if applicable).

- Include that you may bring a civil action suit under ERISA.
- Include any Plan-imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the specific expiration date for bringing suit.

If applicable, the notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

If the Plan fails to comply with the claims and appeals procedure requirements for Loss of Time Benefit claims, you will not be prohibited from filing suit or seeking court review of a claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean:

- 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 by the Plan.

A Change to Covered Air Ambulance Services

Currently, the Plan covers air ambulance services to a hospital, but only in a medical emergency when treatment ordered by your physician is not available locally. The Plan only covers travel to the nearest hospital providing the necessary care.

Effective May 1, 2018, the Plan will change how it covers eligible air ambulance services. To determine the maximum amount that will be reimbursed for such services, the Plan will use the fee set by Medicare and then multiply it by a percentage.

As a result, eligible air ambulance services will be covered at 300% of the Medicare reimbursement rate at the time the services are rendered. Using a Medicare-based rate means that you could pay a larger portion of the cost of your eligible air ambulance services.

Questions?

If you have questions about filing a Loss of Time Benefit claim on and after April 1, 2018, the Plan's coverage for air ambulance services, or about your benefits in general, contact the Fund Office at 866-692-0860 or 309-692-0860. You can also refer to your Summary Plan Description (SPD) and Plan Document, 2016 Edition, for further details. Please keep this notice in the front pocket of your SPD for future reference.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications (SMM), contains 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. Please keep a copy of this SMM with your copy of the Fund's Summary Plan Description (SPD).

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