Central Illinois Carpenters Health & Welfare Trust Fund

200 South Madigan Drive, Lincoln, IL 62656 • (866) 732-1919 • www.cichealth.org

Office Hours: 8:00 a.m. to 4:30 p.m., Monday-Friday

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

NOVEMBER 2023

Dear Plan Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Fund") to change benefits from time to time when the financial soundness of the Fund requires, and at other times to comply with changes to the Federal law or provide notice of updates to the Summary Plan Description. This Summary of Material Modifications contains information regarding updates to your Summary Plan Description ("SPD"). Accordingly, please retain a copy of this Summary of Materials Modifications with your SPD.

EFFECTIVE JANUARY 1, 2024

Delta Dental Network

Dental benefits will be offered through Delta Dental of Illinois ("Delta Dental"), a contracted provider that offers a comprehensive dental network to you and your family. Attached is information from Delta Dental with details on the Delta Dental PPO and Premier provider networks and your Plan coverage information. **Please note that a separate mailing will be sent to you in the coming weeks that will include your Delta Dental ID Card.** While you may continue to go to any licensed general or specialty dentist, you will maximize your dental benefits and savings by receiving care from a Delta Dental PPO or Premier network dentist. Delta Dental also provides you with the ability to register online or download the Delta Dental mobile application to receive "real time" benefit information and check the status of your dental treatment claims. In addition, you may visit the Delta Dental website at www.deltadentalil.com to search for network providers in your area.

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EFFECTIVE JANUARY 1, 2024

Pediatric Dental Coverage

The "Covered Dental Expenses" section of the SPD was amended to remove the Medically Necessity requirement for orthodontia treatment. This section of the SPD now reads as follows:

4. Pediatric dental coverage from birth through age 18 will be provided according to the Schedule of Benefits and include the following:
   - A total of two (2) oral cleanings every twelve (12) months.
   - Preventive dental examinations, including charges for fluoride treatment, sealants, and x-rays.
   - Orthodontia treatment (Note: Plan will provide coverage for eligible treatment charges at 50% after payment of deductible).
   - Restorative crowns and fillings.

EFFECTIVE SEPTEMBER 21, 2023

Board of Trustees Listing

The SPD was amended to reflect recent changes to the Board of Trustees, as follows:

Union Trustees	Employer Trustees
Matthew Bender, Chairman Carpenters Local #237 2412 North Main Street East Peoria, IL 61611	Jeff Fuerst, Secretary Associated General Contractors of Illinois 3219 Executive Drive Springfield, IL 62703
Jeff Bort, Business Representative Millwrights Local #1693 4979 Indiana Avenue, Suite 211 Lisle, IL 60532	Jason Brewer Central Illinois Builders of AGC 300 W. Edwards, Ste. 300 Springfield, IL 62704
Riki Dial Regional Director, Southern Region Mid-America Carpenters Regional Council #1 Kalmia Way Springfield, IL 62702	Nick Hart Greater Peoria Contractors Association 1811 W. Altorfer Drive #1 Peoria, IL 61615
Joshua Robertson, Business Representative Carpenters Local #243 402 S. Duncan Rd Champaign, IL 61821	Michael Sunley Central Illinois Builders of AGC 300 W. Edwards, Ste. 300 Springfield, IL 62704
Matt Watchinski, Business Representative Carpenters Local #237 2412 North Main Street East Peoria, IL 61611	West Zobrist Builders Association of Tazwell County 182 East Washington Street Morton, IL 61550

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits or the Summary Plan Description, please contact the Fund Office toll free at (866) 732-1919.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. 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.

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JASON BREWER
NICK HART
MIKE SUNLEY
WES ZOBRIST

Union Trustees
R. NATHAN GERMAN, CHAIRMAN
MATTHEW BENDER
JEFF BORT
RIKI DIAL
JOSHUA ROBINSON

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

MAY 2023

Dear Plan Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Plan") to change benefits from time to time when the financial soundness of the Plan requires, and at other times to comply with changes to the Federal law or provide notice of updates to the Summary Plan Description. This Summary of Material Modifications contains information regarding updates to your Summary Plan Description ("SPD"). Accordingly, please retain a copy of this Summary of Materials Modifications with your SPD.

TERMINATION OF TEMPORARY EXTENSION OF CERTAIN DEADLINES DUE TO COVID-19

On January 30, 2023, the Biden Administration announced that the National Emergency and Public Health Emergency related to COVID-19 ("National Emergency") will terminate on May 11, 2023. This means that the temporary extension of certain deadlines under the National Emergency will soon end. As a reminder, the Plan was required to disregard the "Outbreak Period," which was generally defined as the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency, with respect to certain deadlines. With the National Emergency exceeding one (1) year, certain deadlines were subsequently disregarded/tolled for a period not to exceed the earlier of:

- One year from the date an individual was first eligible for relief (*i.e.*, an extended deadline); or
- Sixty (60) days from the end of the National Emergency.

This Summary of Material Modifications discusses the changes to the Plan as a result of these emergencies ending.

Under the National Emergency, the following deadlines were temporarily extended for a period up to one (1) year beyond the Plan's normal deadlines, which was dependent upon when the aforementioned relief was first triggered. Following the end of the National Emergency, all Plan deadlines will once again run, consistent with the rules described in the summary plan description ("SPD"), on July 11, 2023. This means that for the following actions, the deadlines described in your SPD will once again apply on July 11, 2023:

- The period to request special enrollment;
- The 60-day election period for COBRA continuation coverage;
- The date for making COBRA premium payments;
- The date for individuals to notify the plan of a qualifying event or determination of disability for purposes of COBRA continuation coverage and the COBRA disability extension;
- The date within which individuals may file a benefit claim under the Plan's claims procedure;
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claim procedures;
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

Any above-listed deadline that is currently suspended, and that has not yet hit its one-year extension, will begin running on July 11, 2023.

TERMINATION OF TEMPORARY COVERAGE FOR COVID-19 TESTING AND OUT-OF-NETWORK COVID-19 VACCINES

As detailed in a previous Summary of Material Modifications, the Plan was required to cover 100% of the Reasonable and Customary Charge for diagnostic testing/screening for COVID-19 without precertification and without cost-sharing during the National Emergency. This temporary coverage also required the Plan to cover the cost of a related office visit and any items and services provided during such visit that related to the provision of testing/screening. With the National Emergency ending on May 11, 2023, the Plan will no longer cover 100% for the Reasonable and Customary Charge for diagnostic testing/screening for COVID-19. Instead, coverage for diagnostic testing/screening for COVID-19 will be covered in accordance with the Plan's SPD.

The Plan was also required to cover a Qualifying Coronavirus Preventive Service, such as COVID-19 vaccines, on an out-of-network basis, without cost-sharing, during the National Emergency. With the National Emergency ending on May 11, 2023, the Plan will no longer cover such Qualifying Coronavirus Preventive Services on an out-of-network basis, without cost-sharing. Instead, coverage for out-of-network Qualifying Coronavirus Preventive Service will be covered in accordance with the Plan's SPD. The Plan will continue to cover qualifying COVID-19 vaccines received from an in-network provider at 100% without application of the deductible.

TERMINATION OF TEMPORARY COVERAGE FOR OVER-THE-COUNTER COVID-19 TESTS

As detailed in a previous Summary of Material Modifications, the Plan was required to cover the full cost of over-the-counter COVID-19 tests as of January 15, 2022. As a reminder, the Plan implemented the direct coverage option, which allowed you to obtain eight (8) over-the-counter COVID-19 diagnostic test kits per covered individual per month free of charge from pharmacies in Express Scripts network and directly from Express Scripts through a shipping option. The Plan also provided the option to receive reimbursement for up to $12.00 for COVID-19 diagnostic test kits purchased at out-of-network pharmacies and retail stores. With the National Emergency ending on May 11, 2023, the Plan will no longer cover over-the-counter COVID-19 tests at 100%. The Plan's usual rules and cost sharing provisions, including deductible, will be

applied to these products. However, your Health Reimbursement Arrangement ("HRA") with the Plan can be used to cover these expenses. Please review your SPD for additional information about the Plan's HRA.

TELEHEALTH VISITS

Finally, please note that the Board of Trustees has decided to continue covering telehealth visits, for reasons other than COVID-19 testing at the same cost sharing amount as office visits under the Plan's terms. That means if your network provider offers telephone or video consultants, you will pay the same amount as if you had visited that provider in person. These benefits include Medical and Mental/Nervous Disorder and Substance Abuse virtual office visits if the provider has the capabilities to provide these visits.

If you have any questions regarding the deadline extensions or the benefit coverage changes described in this notice, contact the Fund Office.

RETIREES RETURNING TO ACTIVE EMPLOYMENT

Effective October 1, 2022, if you retire and return to active employment with an employer that is required to report and pay contributions to the Plan, the employer contributions reported and paid on your behalf will be credited towards your self-payments if you are currently enrolled in the Plan's Retired Participant Program. In the event you are retired and return to active employment but did not previously enroll in the Plan's Retired Participant Program in a timely manner, you will be required to meet the Initial Eligibility requirements described above prior to receiving coverage under the Plan.

If you retire from active employment and you do not enroll in, or qualify for, self-payments under the Plan's Retired Participant Program, you will not be permitted to participate in the Retirement Participant Program in the future should you return to active employment.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits or the SPD, please contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. 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.

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IMPORTANT INFORMATION ABOUT YOUR BENEFITS

JANUARY 2023

Dear Plan Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Fund") to change benefits from time to time when the financial soundness of the Fund requires, and at other times to comply with changes to the Federal law or provide notice of updates to the Summary Plan Description. This Summary of Material Modifications contains information regarding updates to your Summary Plan Description ("SPD"). Accordingly, please retain a copy of this Summary of Materials Modifications with your SPD.

Effective June 23, 2022, language underlined below has been added and incorporated into the SPD; language struckout below has been removed from the SPD:

Section: ***Schedule of Benefits*** (page 5)

	PREFERRED PROVIDERS	**NON-PREFERRED PROVIDERS**
Physician Services **Office visits*, labs, and x-rays** <u>*Includes coverage for in person and telephonic/video office visits</u>	**80%**	**60%**
Physician Services **Occupational Therapy** **Speech Therapy** **Physical Therapy** Occupational, Speech and Physical Therapy visits are a Covered Service if medically necessary due to accident or illness, <u>including mental health or nervous disorders</u>	**80%** 60 visits combined per calendar year maximum <u>Additional visits allowed if Medically Necessary</u>	**60%** 60 visits combined per calendar year maximum <u>Additional visits allowed if Medically Necessary</u>

Section: ***Notices*** (page 8)

<u>**Mental Health Parity and Addiction Equity Act of 2008 Compliance Statement**</u>

<u>The Plan is designed to be fully compliant with the parity requirements set forth under the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). Accordingly, all the Plan's Mental Health/Substance Abuse Disorder benefits, operational review and appeal components are in full parity across each respective benefit classification under which Medical and Surgical benefits are provided under the Plan.</u>

Section: *Covered Medical Expenses* (page 30 & 34)

4. Other Covered Medical Expenses including the following services and supplies:
   - The services of a licensed Physician for professional services, including in person and telephonic/video office visits.
   - Services of a Physician or licensed physical therapist for Medically Necessary outpatient therapy. Outpatient physical therapy, combined with occupational therapy and speech therapy, have a Plan benefit maximum of 60 visits per calendar year per covered person unless the physical therapy is Medically Necessary for the treatment of the following conditions:
     - Fracture;
     - Stroke;
     - Surgery; ~~or~~
     - Palsy or similar muscle diseases; or
     - Mental health or nervous disorder.
   - Services of a Physician or licensed occupational therapist for Medically Necessary constructive therapeutic activity designed and adapted to promote the restoration of useful physical function, including restoration of physical function related to a mental health or nervous disorder. Outpatient occupational therapy, combined with physical therapy and speech therapy, have a Plan benefit maximum of 60 visits per calendar year per person unless additional Medically Necessary Outpatient occupational therapy is required to restore useful physical function.
   - Services of a Physician or licensed speech therapist for Medically Necessary restoratory or rehabilitory speech therapy for speech loss or impairment due to Sickness, Injury, ~~or due to a~~ congenital anomaly, or mental health or nervous disorder. Outpatient speech therapy, combined with physical therapy and occupational therapy, have a Plan benefit maximum of 60 visits per calendar year per person unless additional Medically Necessary outpatient restoratory or rehabilitory speech therapy is required for speech loss or impairment as defined above.

…

10. Benefits will be provided for Outpatient self-management training, education, and medical nutrition therapy to assist with diabetes management or treatment of a mental health or nervous disorder. Benefits will be provided if a Physician renders these services, or duly certified, registered, or licensed health care professional with expertise in the aforementioned practice areas ~~diabetes managment~~. Benefits for such health care professionals will be provided at the benefit level for Other Covered Services. Benefits are also available for regular foot care examinations by a Physician in connection with diabetes management.

Section: *Non-Covered Medical Expenses* (pages 36 - 37)

~~22. Any service, supply or treatment for Speech therapy connected with a learning disability, developmental disorder or functional nervous disorder is not covered. Therapy for conditions when improvement is not anticipated within two (2) months is also not covered.~~

…

41. Expenses Incurred for behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of mental health or nervous disorder.

…

43. Charges made for functional therapy for learning or vocational disabilities or hearing therapy if such therapy is due to developmental delay which is not specifically the result of, or includes a dual diagnosis involving, a mental health or nervous disorder.

Effective December 15, 2022, language underlined below has been updated in the SPD:

Section: *Title Page* (page 1)

Union Trustees	*Employer Trustees*
Nate German, Chairman	Jeff Fuerst, Secretary
Joshua Robertson	Jason Brewer
Jeff Bort	Wes Zobrist
Riki Dial	Michael Sunley
Matthew Bender	Nick Hart

Section: ***Title Page*** (page 1, continued)

...

Administrative Manager

Kristina Guastaferri

...

Consultant

United Actuarial Services

Section: ***Important Information About the Health & Welfare Plan*** (page 84)

Union Trustees	Employer Trustees
Nathan German, Chairman Southern Region Mid-America Carpenters Regional Council #1 Kalmia Way Springfield, IL 62702	Jeff Fuerst, Secretary Associated General Contractors of Illinois 3219 Executive Drive Springfield, IL 62703
Joshua Robertson, Business Representative Carpenters Local #243 402 S. Duncan Rd Champaign, IL 61821	Jason Brewer Central Illinois Builders of AGC 300 W. Edwards, Ste. 300 Springfield, IL 62704
Jeff Bort, Business Representative Millwrights Local #1693 4979 Indiana Avenue, Suite 211 Lisle, IL 60532	Wes Zobrist Builders Association of Tazwell County 182 East Washington Street Morton, IL 61550
Riki Dial, Regional Director Southern Region Mid-America Carpenters Regional Council #1 Kalmia Way Springfield, IL 62702	Michael Sunley Central Illinois Builders of AGC 300 W. Edwards, Ste. 300 Springfield, IL 62704
Matthew Bender, Business Representative Carpenters Local #237 2412 North Main Street East Peoria, IL 61611	Nick Hart Greater Peoria Contractors Association 1811 W. Altorfer Drive #1 Peoria, IL 61615

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits or the Summary Plan Description, please contact the Fund Office toll free at (866) 732-1919.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. 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.

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JEFF BORT
JOSHUA ROBERTSON

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

JUNE 2022

Dear Plan Participant and Covered Dependent(s):

As you know from previous notification mailings, the Coronavirus Disease 2019 (COVID-19) resulted in a declaration of National Emergency beginning on March 1, 2020. To assist participants and dependents of group health plans, the U.S. Department of Labor, and Department of Treasury ("Agencies") published a Final Rule on May 4, 2020 which retroactively extends certain pre-established deadlines related to special enrollment periods, COBRA continuation coverage, COBRA premium payments, filing of claims and benefit appeals. The COVID-19 National Emergency was again continued in effect to March 1, 2022, which extended those same pre-established deadlines.

On February 18, 2022, President Joseph Biden formally extended the COVID-19 National Emergency a third time to March 1, 2023. Due to this recent extension of the National Emergency to March 1, 2023, the deadline extensions in the Final Rule continue to apply to you and your dependents as covered individuals enrolled in the Central Illinois Carpenters Health & Welfare Trust Fund (the "Welfare Plan"). This notice is intended to communicate and explain those ongoing deadline extensions.

The existing deadlines for the following items will again be "delayed" until **60** days after the announced end of the Coronavirus National Emergency (or an alternative date yet to be determined by the Agencies):

Welfare Plan HIPAA Special Enrollment Period

- If you acquire a dependent through a qualifying event such as marriage, birth of a child, adoption, placement for adoption of a child or obtaining legal guardianship of a child, the Welfare Plan will accept your completed enrollment form and enroll the new dependent if the enrollment form (and all requested supporting documentation) is received by the Welfare Plan within 60 days after the expiration of the new deadline period described above. *For example, if you had a qualifying event as described above on May 1, 2022 and the National Emergency ends on August 1, 2022, you will have 60 days from September 30, 2022 (i.e., November 29, 2022) to submit your completed enrollment form and all supporting documentation.*
- If your dependent loses eligibility for Medicaid or CHIP coverage or becomes eligible for a premium assistance under Medicaid or CHIP, the Welfare Plan will accept your completed enrollment form and enroll the new dependent if the enrollment form (and all requested supporting documentation) is received by the

Welfare Plan within 60 days after the expiration of the new deadline period described above. *For example, if you had a qualifying event as described above on May 1, 2022 and the National Emergency ends on August 1, 2022, you will have 60 days from September 30, 2022 (i.e., November 29, 2022) to submit your completed enrollment form and all supporting documentation.*

Welfare Plan COBRA Continuation Coverage

- If you or your dependent experience a Qualifying Event (such as your loss of employment or reduction of hours, a dependent spouse's divorce or legal separation, or a child ceasing to qualify as a dependent) the Welfare Plan will accept your COBRA election form and consider it to be timely submitted if it is received by the Welfare Plan within 60 days after the expiration of the new deadline period described above. *For example, if you or your dependent had a qualifying event as described above on May 1, 2022 and the National Emergency ends on August 1, 2022, you will have 60 days from September 30, 2022 (i.e., November 29, 2022) to submit the completed COBRA election form for coverage purposes.*

- If you or your dependent experience a Qualifying Event, submit a completed COBRA election form and are enrolled for coverage, the monthly COBRA premium you must pay for continuation coverage will be considered timely if received by the Welfare Plan within 30 days after the expiration of the new deadline period described above. After all outstanding COBRA premium payments are received, you or your dependent will have coverage retroactively to the COBRA election/enrollment date. *For example, if you or your dependent are fully enrolled for COBRA continuation coverage as of May 1, 2022 and the National Emergency ends on August 1, 2022, you will have 30 days from September 30, 2022 (i.e., October 30, 2022) to pay the COBRA premiums owed for May through November and have claims incurred during that period subject to processing and payment by the Plan.*

Welfare Plan Filing of Benefit Claims

- In most circumstances, health care providers, dental offices and pharmacies will file claims on your behalf. However, the Welfare Plan will now consider a claim to be filed in a timely manner if it is incurred and received at the Welfare Plan Office (from you or a provider) within 12 months after the expiration of the new deadline period described above. *For example, if you received medical treatment services on May 1, 2022, and the National Emergency ends on August 1, 2022, you or the provider will have 12 months from September 30, 2022 (i.e., September 30, 2023) to file the claim with the Welfare Plan.*

Welfare Plan Benefit Claim Appeals and External Review Requests

- If you or your dependent receive an Adverse Benefit Determination by the Welfare Plan (with respect to medical benefits or a rescission of coverage) the deadline to file a written appeal with the Welfare Plan to dispute the Adverse Benefit Determination will be considered timely if it is received within 180 days after the expiration of the new deadline period described above. *For example, if you received notice of an adverse benefit determination on May 1, 2022, and the National Emergency ends on August 1, 2022, you or your dependent will have 180 days from September 30, 2022 (i.e., March 29, 2023) to file a written appeal with the Welfare Plan.*

- In addition, if the Welfare Plan denies your appeal (whether in whole or in part) and you receive a Final Adverse Benefit Determination, you or your dependent's request for an external review of the Welfare Plan's Final Adverse Benefit Determination - and any subsequent information submitted by your or your dependent to support the request for external review - will be considered timely if it is received within 4 months after the expiration of the new deadline period described above. *For example, you or your dependent filed a written appeal with the Welfare Plan on May 1, 2022. You receive a Final Adverse Benefit Determination from the Welfare Plan on June 1, 2022. The National Emergency ends on August 1, 2022. Your or your dependent will*

have 4 months from September 30, 2022 (i.e., January 30, 2023) to file a written request for external review of the Final Adverse Benefit Determination.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits or the Summary Plan Description, please contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

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IMPORTANT INFORMATION ABOUT YOUR BENEFITS

May 2022

Dear Plan Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Fund") to change benefits from time to time when the financial soundness of the Fund requires, and at other times to comply with changes to the Federal law. This Summary of Material Modifications contains important information about recent changes to benefits and coverages provided through the Fund. Accordingly, please retain a copy of this Summary of Material Modifications with your Summary Plan Description.

At-Home COVID-19 Tests Available from Federal Government

In addition to coverage of at-home COVID-19 tests through the Plan (see below), please note that every home in the U.S. is eligible to order between 4-8 free at-home COVID-19 Tests from the federal government. You may order free tests from the federal government through the web site https://www.covidtests.gov/. Please note that COVID-19 Test coverage is an expense to the Plan – consequently, we strongly encourage all Participants to first utilize this federal program for COVID-19 Tests.

Coverage of At-Home COVID-19 Tests as of January 15, 2022

On Monday January 10, 2022, federal agencies issued guidance stating that health plans are required to cover the cost of over-the-counter COVID-19 tests. Over-the-counter COVID-19 tests are COVID-19 tests that have been authorized by the FDA for emergency use at home or elsewhere without involvement of a health care provider.

As required by the federal guidance, the Fund will provide coverage for at-home COVID-19 tests subject to the following provisions. These provisions only apply to at-home COVID-19 tests. That is, these provisions do not affect previous Summary Plan provisions regarding coverage of COVID-19 tests that are not at-home COVID-19 tests.

- At-home COVID-19 tests are covered by the Fund if purchased on or after January 15, 2022 and through the end of the COVID-19 Public Health Emergency declared by the Department of Health and Human Services.

- ***Only tests that have been approved by the FDA for emergency use at home or elsewhere without involvement of a health care provider*** will be covered under this program. Please go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test before purchasing.

- The Fund will cover the cost of at-home COVID-19 tests without cost-sharing (no Deductible or Copay) if the tests are purchased through a pharmacy in the Express Scripts network.

- All pharmacies in the Express Scripts network are set up to process at-home COVID-19 tests in the same manner as a prescription. In these pharmacies, you can present your Express Scripts Prescription card to the pharmacy and the COVID-19 tests will be covered at 100%. This means that you will not have to pay anything for the tests.

- For out-of-network pharmacies and retail stores, you must pay for the COVID-19 tests upfront and out-of-pocket. You will be reimbursed for the entire cost of the tests if you save your receipt of purchase and submit the receipt along with the "Prescription Drug Reimbursement" form to Express Scripts at the address listed in the form. Reimbursement request forms are available at, and completed forms can be uploaded/filed to, https://express-scripts.com/covid-19/resource-center. Reimbursement will be provided to you for up to $12 per test or the cost of the test, whichever is less. Amounts that you pay in excess of $12 for tests purchased at pharmacies that are not in the Express Scripts network will not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum.

- You may also order at-home COVID-19 tests through the Express Scripts Mail Order Pharmacy. To do so, go to https://express-scripts.com/covid-19/resource-center and click on the log-in link under the "Express Scripts Pharmacy" heading. The tests will be shipped to you for free.

- If you have any questions about at-home COVID-19 test coverage, you may also call Express Scripts directly at the phone number listed on the back of your Express Scripts ID Card.

- Coverage is provided for up to eight (8) at-home COVID-19 tests per Covered Person under the Fund every 30 days.

- Covered tests include only those for at-home medical use by you or your covered household family members. Tests for employment purposes or resale will not be covered or reimbursed under this program.

- Please be advised that any COVID-19 test reimbursement that is improperly paid by the Fund as a result of falsified or fraudulent information will entitle the Fund to recover the amount of the improper reimbursement or offset prospective coverage under the Plan up to the amount of the reimbursement.

A Final Note

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Sincerely,

Board of Trustees

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JASON BREWER	CARL BIMM
NICK HART	JEFF BORT
MIKE SUNLEY	JOSHUA ROBERTSON

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

January 2022

Dear Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Fund") to change benefits from time to time when the financial soundness of the Fund requires, and at other times to comply with changes to the Federal law. This Summary of Material Modifications ("SMM") advises you of changes to the Fund's plan of benefits in order to comply with the No Surprises Act (the "NSA"), effective January 1, 2022. Accordingly, please retain a copy of this SMM with your Plan Description booklet.

The NSA was signed into law in December 2020 and generally protects patients from "balance billing" for Out-of-Network emergency services or facilities, Out-of-Network air ambulance services, and certain non-emergency services performed by an Out-of-Network provider at an In-Network facility (collectively "No Surprise Services").

As described in more detail below, Participants and Dependents receiving No Surprise Services will generally only be responsible for paying their In-Network cost sharing. You are still encouraged to use In-Network facilities and participating providers whenever possible. Additionally, this SMM describes other changes required by the NSA, including expanded emergency services and continuity of care provisions.

Consequently, the following changes are made to the Fund's plan of benefits effective January 1, 2022:

EMERGENCY SERVICES

The NSA requires emergency services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. Without regard to whether the health care provider furnishing the emergency services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on Out-of-Network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from In-Network Providers and In-Network emergency facilities;

4. Without imposing cost-sharing requirements on Out-of-Network emergency services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;

5. By calculating the cost-sharing requirement for Out-of-Network emergency services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and;

6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider.

NON-EMERGENCY SERVICES PERFORMED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY

The No Surprises Act requires non-emergency services performed by an Out-of-Network Provider at an In-Network Health Care Facility to be covered as follows:

1. 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;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the recognized amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on your Out-of-Network coverage (meaning your Out-of-Network cost sharing will apply) if:

a. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, 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; and

b. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary services and items, or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

PAYMENTS TO OUT-OF-NETWORK PROVIDERS AND FACILITIES

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at In-Network Facilities by out-of-network Providers, and Air Ambulance Services

within 30 calendar days of receiving a clean claim from the out-of-network provider. The 30 day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the Participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

CONTINUITY OF COVERAGE

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and

2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

INCORRECT PROVIDER INFORMATION

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

If you obtain and rely upon incorrect information about whether a provider is in-network from the Plan or its administrators, the Plan will apply in-network cost-sharing to your claim, even if the provider was out-of-network at the time the service was rendered.

COMPLAINT PROCESS

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office at 866-732-1919 or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

EXTERNAL REVIEW OF CERTAIN COVERAGE DETERMINATIONS

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by an out-of-network provider at an in-network facility, and/or Air Ambulances service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

NEW DEFINITIONS

Due to the nature of the changes required by the NSA, the Fund has adopted the following definitions, which will assist you in fully understanding the changes required by the NSA:

Air Ambulance means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Ancillary services are, with respect to a health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Cost sharing means the amount a Participant or Dependent is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the Plan.

The **Cost Sharing Amount** for Emergency and Non-emergency Services at In-Network Facilities performed by Out-of-Network Providers, and air ambulance services from Out-of-Network providers will be based on the Recognized Amount.

Continuing Care Patient means an individual who, with respect to a provider or facility-

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;

2. is undergoing a course of institutional or inpatient care from the provider or facility;

3. is 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;

4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

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.

Emergency Services means the following:

1. 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

2. 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).

Emergency Services furnished by an out-of-network provider or an out-of-network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also 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 Dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The Participant or Dependent is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of 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; and
- The Participant or Dependent gives informed consent to continued treatment by the out-of-network provider, acknowledging that the Participant or Dependent understands that continued treatment by the out-of-network provider may result in greater cost to the Participant or Dependent.

Health Care Facility (for non-emergency services) is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);

2. A hospital outpatient department;

3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

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

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Out-of-Network/Non-PPO emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the Plan or coverage respectively.

Out-of-Network/Non-PPO provider means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Out-of-Network Rate with respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

Recognized Amount means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. An amount determined by a specified state law; or

3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

For air ambulance services furnished by out-of-network providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Serious and Complex Condition means with respect to a Participant, Dependent, or enrollee under the Plan one of the following:

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

In the context of Continuity of Care, **Termination** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Summary Plan Description document, contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. 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.

Central Illinois Carpenters Health & Welfare Trust Fund
200 South Madigan Drive, Lincoln, IL 62656
Office Hours: 8:00 am to 4:30 pm Monday-Friday
Phone: 866-732-1919 ~ Website: www.cichealth.org

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STEVE AUPPERLE	MATTHEW BENDER
JASON BREWER	CARL BIMM
NICK HART	JEFF BORT
MIKE SUNLEY	JOSHUA ROBERTSON

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

October 2021

Dear Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Fund") to change benefits from time to time when the financial soundness of the Fund requires, and at other times to comply with changes to the Federal law. This Summary of Material Modifications contains important information about recent changes to benefits and coverages provided through the Fund. Accordingly, please retain a copy of this Summary of Material Modifications with your Summary Plan Description.

Disability Benefit Increase

Effective January 1, 2022, the Plan's occupational and non-occupational weekly disability benefit will be available to Eligible Participants up to an increased maximum of 18 total weeks per disability.

Life Insurance Benefit Increase

Effective January 1, 2022, the Plan's life insurance benefit for Active Participants and Eligible Retirees up to age 70 will be increased from $5,000 to $10,000 regardless of whether the cause of death is accidental or non-accidental.

Self-Payment Option

Effective January 1, 2022, the Plan's Self-Pay Option will be available to eligible Active Status Participants and surviving Dependents of a deceased Active Status Participant for a maximum period of six (6) consecutive Benefit Quarters. All other requirements of the Plan's Self-Pay Option will remain unchanged. This limitation will not apply to Disabled Participants who are found eligible for the Plan's Self-Pay Option or the Plan's Retiree Self-Pay Option.

EAP Provider Offers Free Services

As a reminder, the Employee Assistance Program is provided by ComPsych GuidanceResources. This program is free to Participants and their Dependents. Services include counseling, legal and financial consultation and work-life assistance to all members and their household family members (dependents).

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The program is available 24 hours per day, 365 days a year and is confidential ~ no personal information will be shared with the Plan or its designees.

The EAP is designed to provide short-term counseling services with up to 6 sessions per issue per year. You also have access to a website with information on many topics including relationships, work, school, children, wellness, legal and financial. You may search for local child and elder care, attorneys and financial planners as well as ask questions, take self-assessments and more. The Plan's web ID is: CIC and then you can register for your own login at guidanceresources.com. The Plan has its own dedicated phone line at 800-272-7255 and you'll speak to a counseling professional who will listen to your concerns and guide you to the appropriate service.

Reciprocal Transfer

If you work out of the area of the Southern Region of the Chicago Regional Council of Carpenters, you will need to contact the Fund Office at 866-732-1919 to obtain a reciprocal (transfer) form to have your hours transferred back to the Central Illinois Carpenters Health and Welfare Trust Fund Office in Lincoln.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Plan Description document, contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

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IMPORTANT INFORMATION ABOUT YOUR BENEFITS

June 2021

Dear Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Fund") to change benefits from time to time when the financial soundness of the Fund requires, and at other times to comply with changes to the Federal law. This Summary of Material Modifications contains important information about recent changes to benefits and coverages provided through the Fund. Accordingly, please retain a copy of this Summary of Materials Modifications with your Summary Plan Description.

Health Reimbursement Arrangement (HRA)

In 2021, the Central Illinois Carpenters Health and Welfare Board of Trustees established a Health Reimbursement Arrangement (HRA) for your benefit.

Starting with May 2021 work hours, $0.50 per welfare hour contributed on your behalf will be applied to your HRA account. This includes reciprocal welfare hours that are received in the Central Illinois Carpenters Fund Office ("Fund Office"). The benefit is $0.50 cents for each welfare hour (regardless of straight, over or double time) that is worked by you and paid in to the Fund Office. Contributions will be credited to HRA accounts the month after they are received by the Fund Office (i.e. May work hours paid in June will be credited to HRA accounts in July).

The Fund has included an extensive series of Q&A's below which address and discuss specific information about the HRA.

Q1. What is an HRA?

A1. The Central Illinois Carpenters HRA is a tax-advantaged account that can be used to pay for, or reimburse you for, out-of-pocket costs for eligible health care expenses for yourself and eligible dependents.

Q2. How do I create my HRA account?

A2. An HRA account will be automatically created for you when funds are first available. Your mailing address on file at the Fund Office will be used for your HRA account so immediately contact the Fund Office (phone 217-732-1919) if you have a change of address.

Q3. Who is TASC?
A3. TASC is the third-party administrator who administers the Central Illinois Carpenters HRA benefit. Once your HRA account has been created, you will be mailed a welcome packet from TASC with information on how to set up an online/mobile app account. In a separate mailing, a plain white envelope will include your TASC Card (will look like a credit card). **YOU MUST CALL TASC customer service (7 am – 8 pm central time) at 800-422-4661 and give them your email address so you can access your HRA account online.** *The Fund Office is not sending your Social Security Number to TASC*. Please open all your mail. The TASC logo looks like this:

Q4. What if I do not receive a TASC Card in the mail?
A4. If you do not receive a TASC Card in a plain white envelope within 10 business days of receiving the TASC welcome packet in the mail, please call TASC customer service at 800-422-4661 to request a replacement card. The Fund Office staff does not have access to your HRA account and cannot provide you with a replacement TASC Card.

Q5. How do I access my account?
A5. You must be a member in Good Standing with your Local Union (dues must be current and not in arrears) to access your account. Access to your HRA account will be through an on-line/mobile platform with TASC customer service personnel available to assist you.

Q6. What do I do if I lose my TASC Card?
A6. Log in to your TASC account and then you may place a block on the card so it cannot be used (while you look for it) or you can permanently terminate it and request a new card be issued. Contact TASC customer service at 800-422-4661 for assistance if needed.

Q7. What if I want an extra card for my spouse to use?
A7. If you want a second card for your spouse to use, you may request it within your online account options or by contacting TASC at the customer service number listed above.

Q8. Can I contact the Fund Office about my HRA account?
A8. Please contact TASC customer service at 800-422-4661 with any and all questions about your HRA account or reimbursements. The Fund Office staff does not have access to your HRA account.

Q9. What are HRA-eligible expenses?
A9. HRA-eligible expenses include medical, prescription drug, dental, vision and hearing services that you or your eligible dependents incur and are not covered by insurance such as copays, deductible and co-insurance. More examples of eligible expenses may be found at www.irs.gov/publications/p502. Basically, as long as the expense is related to a health need and is not considered cosmetic, it will be eligible. For example, a cavity filling is eligible but teeth whitening is not.

Q10. How do I use my HRA money to pay for eligible expenses?
A10. Your TASC Card may be used at a point of sale for eligible expenses such as the pharmacy counter or a doctor’s office. If you have already paid for an eligible expense and want to request

reimbursement from your account, you must submit your expense information to TASC. Once logged in to your account, TASC provides instructions on how to request reimbursement.

Q11. How do I receive reimbursement money from my HRA account?
A11. Reimbursement will be placed on your TASC Card in the *MyCash* account which allows you to use the TASC Card like a credit card anywhere MasterCard is accepted. However, you also have a few reimbursement options that are available within your online account: you may elect to have a paper check mailed to you, or you may elect to have TASC make a direct deposit into your bank account ($25 minimum deposit) at no charge. For the direct deposit option, you will need to provide your bank information to TASC. Your TASC Card will work at an ATM to withdraw *MyCash* balances as long as you first set up a PIN within your HRA account - keep in mind, you will be subject to any fees charged by the ATM.

Q12. Can I buy over-the-counter medicines with my HRA money?
A12. Yes, over-the-counter items approved by the IRS are eligible for your HRA. Depending on where you buy the items, you may be able to use your TASC Card. If the store has not coded their computer system to differentiate between eligible and non-eligible items, you will need to request reimbursement from your HRA account. Usually, a pharmacy counter checkout is coded to know which items are eligible for your HRA.

Q13. Can I use my TASC Card for mail order prescriptions?
A13. Yes, you may provide the prescription mail order company with your TASC Card number for them to process your prescription copay. You must keep your receipt showing the details of the payment because you may be asked by TASC to substantiate the expense. Contact TASC customer service with any issues you encounter when using your TASC Card over the phone with a pharmacy or doctor's office.

Q14. What if I incurred an HRA-eligible expense before May 2021?
A14. Although the 50 cents per hour contribution to your account begins with May 2021 work hours, the HRA benefit year is a calendar year so eligible expenses incurred in the year 2021 would be eligible for reimbursement from your HRA account after May 1, 2021. As an example, this means if you already paid your dental deductible towards services you received in February 2021, you would be able to submit (once there is money in your HRA) proof of payment and an itemized statement or explanation of benefits (EOB) page and request reimbursement from your account.

Q15. Can I get reimbursed by my HRA for a medical service I had in 2020 but paid for in 2021?
A15. No, the HRA plan year is a calendar year and reimbursement is based on the date a service is received/incurred and not the date you pay for it.

Q16. Is there a deadline to submit an expense for reimbursement?
A16. Yes, services incurred in one calendar year must be submitted for reimbursement by March 31 of the following year (if you want to request reimbursement or make payment for those services).

Q17. Do I have to use my HRA money for expenses now or can I let my account increase over time?
A17. You have the choice of how/if you want to use your HRA money. You are not required to use your HRA money now. Your HRA account balance (if any) rolls over each calendar year with no limit on the account balance which allows you to build up a higher balance to use later.

Q18. Do I have to be "covered" (i.e., eligible for benefits) under the Health Plan to have an HRA or to use my HRA?
A18. No, you do not have to be covered by the Central Illinois Carpenters Health Plan to have an HRA account or to use your HRA money.

Q19. Do I have to be active status to use my HRA account?
A19. No, you can be an active or retired member and use your HRA account. However, you must be a member in Good Standing with your Local Union (dues must be current and not in arrears) to access your account.

Q20. Can I use my HRA money to self-pay for coverage in the Health Plan?
A20. Yes, you may use your HRA money towards a self-payment to continue coverage if you lose eligibility due to lack of work hours or to continue health insurance coverage via retiree self-payment. To be reimbursed from your HRA for a self-payment, you will need to first make a payment to the Fund Office and then submit your paid receipt to TASC for reimbursement. The Fund Office cannot process payment from your TASC Card.

Q21. What if my expense or self-payment amount costs more than the balance in my HRA account?
A21. You may only use, or be reimbursed, up to the dollar amount available in your HRA account.

Q22. How often will contributions be applied to my HRA account?
A22. Contributions will be applied once a month to your HRA account. Contributions will be credited to HRA accounts the month after they are received by the Fund Office (i.e. June work hours paid in July will be credited to HRA in August).

Q23. Does my disability crediting of hours or my self-payment count towards my HRA account?
A23. No, a crediting of hours while receiving disability benefits or via paycheck stub credit does not count towards HRA funding. Any self-payment to continue health plan coverage does not count towards HRA funding. This includes active, retiree and COBRA self-payments. Only paid welfare hours for work performed May 1, 2021 and after are eligible for HRA contributions.

Q24. What if I leave covered employment or retire?
A24. If you leave covered employment or retire you may continue using your HRA account to pay for eligible expenses as long as you remain in Good Standing status with the Local Union.

Q25. Who pays the administrative fee for my HRA account?
A25. The Central Illinois Carpenters Health Plan pays the monthly administrative fee.

Q26. Do I need to keep my receipts for services/items covered by my HRA account?
A26. Yes, you may need to submit your receipt(s) to TASC to substantiate an expense. This is an IRS requirement. If your expense is not eligible per the IRS, your claim may be denied and/or you may have to pay taxes on the money reimbursed from your HRA account. TASC will contact you if they need an itemized receipt.

Q27. Will I earn interest on the money in my HRA account?
A27. No, your HRA account is non-interest bearing – it is not a bank or investment account.

Q28. Can I make a payment into my HRA account?
A28. No, you cannot make any self-payments into your HRA account.

Q29. Is my HRA account a vested benefit?
A29. No, your HRA account is not a vested benefit.

Q30. Is it possible for my HRA account to be forfeited?
A30. Yes, your HRA account will be forfeited permanently if you do not return to a member in Good Standing status within 12 months or if you are an apprentice and drop out of the program or if your account balance is below $100 and there is no account activity for 24 consecutive months. Per the Affordable Care Act, you may also voluntarily forfeit your HRA account.

Q31. What if I die and there is money in my HRA account?
A31. The HRA account is permanently forfeited if you die and are not survived by dependents. If you have a legal dependent(s), s/he can use any balance remaining in your HRA account as long as the dependent(s) remains eligible for coverage with the Central Illinois Carpenters Health Plan. No death benefit payment or transfer from the account is permitted under law.

Q32. Who is Eligible for the Central Illinois Carpenters HRA benefit?
A32. Members of Locals #237, #243, #270 as well as #1693 members that reside in the Southern Region of the Chicago Regional Council of Carpenters (formerly #1051). Also, individuals covered by a Participation Agreement with the Central Illinois Carpenters Health and Welfare Trust Fund.

Temporary Extension of Certain Deadlines

As you may recall, the Fund previously had to extend certain deadlines relating to special enrollment, claims, COBRA, appeals, external review, etc. as a result of federal legislation addressing the COVID-19 pandemic. Due to updated federal guidance addressing the COVID-19 pandemic, the Fund will continue to temporarily extend certain deadlines as described below. Last year, you received a similar notice advising you that the below-noted deadlines were extended by disregarding the "Outbreak Period," which was generally defined as the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency relating to the COVID-19 pandemic (or such other date as announced by the federal government). In other words, certain deadlines were tolled. Since the National Emergency related to the COVID-19 pandemic has lasted longer than a year, the federal government issued updated guidance noting that the tolling period ends the earlier of:

1. One year from the date an individual was first eligible for relief; or

2. Sixty (60) days from the end of the National Emergency related to the COVID-19 pandemic, which is ongoing.

Consequently, and in general, the foregoing means that you will likely receive a one-year extension of the following deadlines as long as the National Emergency related to the COVID-19 pandemic continues:

- **The period to request special enrollment;**
- **The 60-day election period for COBRA continuation coverage;**
- **The date for making COBRA premium payments;**

- **The date for individuals to notify the plan of a qualifying event or determination of disability for purposes of COBRA continuation coverage and the COBRA disability extension;**
- **The date within which individuals may file a benefit claim under the Plan's claims procedure;**
- **The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claim procedures;**
- **The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and**
- **The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.**

This one-year extension exists because certain deadlines are disregarded/tolled. Consequently, once the tolling period ends, the Fund's normal deadlines will once again apply. Please note that in no case will a disregarded period exceed one year. Please also note that these extended deadlines may be shorter than one year for certain individuals depending on the date the National Emergency is declared over. Finally, these changes are temporary and subject to change based upon additional federal guidance.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Plan Description document, contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. 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.

Central Illinois Carpenters Health & Welfare Trust Fund

200 South Madigan Drive, Lincoln, IL 62656
Office Hours: 8:00 am to 4:30 pm Monday-Friday
Phone: 866-732-1919 ~ Website: www.cichealth.org

Employer Trustees	*Union Trustees*
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JASON BREWER	CARL BIMM
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MIKE SUNLEY	JOSHUA ROBERTSON

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

January 2021

Dear Participant and Covered Dependent(s):

In light of the continued impact of COVID-19, the Trustees of the Central Illinois Carpenters Health and Welfare Trust Fund (the "Plan") recently amended the Plan to include the following benefit enhancements for you and your family:

Initial Eligibility and Lookback Eligibility Requirements

Effective **December 17, 2020**, the Plan was temporarily amended to provide the following eligibility assistance measures:

- The number of hours required for initial Welfare Plan eligibility for Actively at Work Participants shall be temporarily reduced, through August 31, 2021, from 500 hours to 400 hours in the prior consecutive 12-month period; and
- The Plan's 15-month eligibility "lookback" period is temporarily reduced - for all Actively at Work Participants who are eligible for coverage during the December 2020/January 2021/February 2021 Benefit Quarter - from 1,000 hours to 750 hours for the upcoming March 2021/April 2021/May 2021 and June 2021/July 2021/August 2021 Benefit Quarters.

Please note that both of the above Plan eligibility assistance measures **shall not be applicable or made available to retirees**, no matter whether the retiree is in self-pay status, running out accrued hours, or otherwise.

Welfare Plan COVID-19 Vaccine Benefits

Effective **January 1, 2021**, the Plan is hereby temporarily amended until April 21, 2021 (or to such later dates as required by the U.S. Department of Health & Human Services) to provide the following mandatory COVID-19 benefit enhancements:

- For both in-network and out-of-network providers, the Welfare Plan will temporarily cover 100% of the cost of COVID-19 vaccinations and related administrative services under the Plan's prescription drug benefit and medical benefit program.

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OTHER IMPORTANT INFORMATION:

Quarterly Status Report

Your quarterly status report indicates your work hours reported to Fund Office and you should review it to ensure all of your work hours are being reported. You should contact the Fund Office about any discrepancy in hours within 15 days of receiving your report. This report is very important because it states if you are eligible or not for Health Plan benefits. The report is mailed to your address on file at the Fund Office each quarter: i.e. October, November and December work hours submitted to the Fund Office by January 31 with report mailed during early February. **You are responsible to contact the Fund Office if you do not receive your quarterly status report.** Please call the Fund Office with any questions concerning your hours.

EAP Provider Offers Free Services

The Employee Assistance Program is provided by ComPsych GuidanceResources. This program is free to members and their dependents. Services include counseling, legal and financial consultation and work-life assistance to all members and their household family members (dependents). The program is available 24 hours per day, 365 days a year and is confidential ~ no personal information will be shared with the Plan or its designees.

The EAP is designed to provide short-term counseling services with up to 6 sessions per issue per year. You also have access to a website with information on many topics including relationships, work, school, children, wellness, legal and financial. You may search for local child and elder care, attorneys and financial planners as well as ask questions, take self-assessments and more. The Plan's web ID is: CIC and then you can register for your own login at guidanceresources.com. The Plan has its own dedicated phone line at 800-272-7255 and you'll speak to a counseling professional who will listen to your concerns and guide you to the appropriate service.

Reciprocal Transfer

If you work out of the area of the Southern Region of the Chicago Regional Council of Carpenters, you will need to contact the Fund Office at 866-732-1919 to obtain a reciprocal (transfer) form to have your hours transferred back to the Central Illinois Carpenters Health and Welfare Trust Fund Office in Lincoln.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Plan Description document, contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

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IMPORTANT INFORMATION ABOUT YOUR BENEFITS

NOVEMBER 2020

Dear Participant and Covered Dependent(s):

The Trustees of the Central Illinois Carpenters Health and Welfare Trust Fund (the "Plan") have amended the Plan to include the following benefit enhancement for you and your family:

January 1, 2021: Routine Eye Exam with Zero Copay when Utilizing an In-Network Provider

In an effort to enhance your wellness benefits, effective January 1, 2021, the Plan will provide each eligible Participant with a free routine eye exam (using dilation testing) when a VSP in-network provider is utilized. To assist with utilizing this benefit, you may create an account at vsp.com to review your coverage, find a network doctor, get money-saving offers, and more with 24/7 access online.

Welfare Plan COVID-19 Testing Benefits

Due to a recent extension of the Federal Coronavirus Health Emergency Declaration, the Plan will continue to provide the following temporary benefits enhancements for COVID-19 testing for you and your qualified Dependents until January 21, 2021:

- For both in-network and out-of-network providers, the Plan will temporarily cover 100% of the cost of FDA approved in vitro (laboratory) diagnostic products used to detect or diagnose COVID-19 and SARS-COV-2, the virus that causes COVID-19. This coverage will include the costs related to the administration of these in vitro diagnostic products as well. No prior authorization is required.
- For both in-network and out-of-network providers, the Plan will also temporarily cover 100% of the cost of items and services furnished during a health care provider visit, urgent care center visit, and/or emergency room visit (whether it is an in-person or telemed/virtual visit) that results in an order for in vitro diagnostic products or administration of in vitro diagnostic products to detect or diagnose COVID-19 and/or SARS-COV-2, the virus that causes COVID-19. No prior authorization is required.
- If you or a covered dependent are tested for COVID-19 and receive a bill to pay, please contact the Fund Office at the number listed below. Please note: Coronavirus testing kits for use at home are not covered.

As a reminder, the Plan also covers telemedicine/virtual physician office visits like in-person office visits (deductible and coinsurance). **This means you or your covered dependent may not need to go to a doctor's office which can reduce your exposure to others who are sick and also reduce the spreading of germs if you are sick.** The Plan covers these virtual visits unrelated to the coronavirus so

~ OVER ~

they are an option for you regardless of your illness. Please contact your doctor to find out more about his/her offering of telemedicine/virtual office visits.

OTHER IMPORTANT INFORMATION:

Quarterly Status Report

Your quarterly status report indicates your work hours reported to Fund Office and you should review it to ensure all of your work hours are being reported. You should contact the Fund Office about any discrepancy in hours within 15 days of receiving your report. This report is very important because it states if you are eligible or not for Health Plan benefits. The report is mailed to your address on file at the Fund Office each quarter: i.e. July, August and September hours submitted to the Fund Office by October 31 with report mailed during early November. **You are responsible to contact the Fund Office if you do not receive your quarterly status report.** Please call the Fund Office with any questions concerning your hours.

EAP Provider Offers Free Services

The Employee Assistance Program is provided by ComPsych GuidanceResources. This program is free to members and their dependents. Services include counseling, legal and financial consultation and work-life assistance to all members and their household family members (dependents). The program is available 24 hours per day, 365 days a year and is confidential ~ no personal information will be shared with the Plan or its designees.

The EAP is designed to provide short-term counseling services with up to 6 sessions per issue per year. You also have access to a website with information on many topics including relationships, work, school, children, wellness, legal and financial. You may search for local child and elder care, attorneys and financial planners as well as ask questions, take self-assessments and more. The Plan's web ID is: CIC and then you can register for your own login at guidanceresources.com. The Plan has its own dedicated phone line at 800-272-7255 and you'll speak to a counseling professional who will listen to your concerns and guide you to the appropriate service.

A Final Note

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SUMMARY OF MATERIAL MODIFICATIONS
IMPORTANT INFORMATION ABOUT YOUR BENEFITS IN RELATION TO THE *CORONAVIRUS*

MAY 2020

Dear Plan Participant and Covered Dependent(s):

As a result of Coronavirus Disease 2019 (COVID-19) President Trump declared a National Emergency beginning on March 1, 2020. To assist participants and dependents of group health plans, the U.S. Department of Labor and Department of Treasury ("Agencies") published a Final Rule on May 4, 2020 which retroactively extends certain pre-established deadlines related to special enrollment periods, COBRA continuation coverage, COBRA premium payments, filing of claims and benefit appeals. Due to the fact the deadline extensions in this Final Rule apply to you and your dependents as covered individuals enrolled in the Central Illinois Carpenters Health & Welfare Trust Fund (the "Plan"), this notice is intended to communicate and explain those deadline extensions.

Effective March 1, 2020, the Plan's existing deadlines for the following items will be "delayed" until **60** days after the announced end of the Coronavirus National Emergency (or an alternative date yet to be determined by the Agencies):

HIPAA Special Enrollment Period

- If you acquire a dependent through a qualifying event such as marriage, birth of a child, adoption, placement for adoption of a child or obtaining legal guardianship of a child, or if your dependent loses eligibility for Medicaid or CHIP coverage or becomes eligible for a premium assistance under Medicaid or CHIP, the Plan will accept your completed enrollment form and enroll the new dependent if the enrollment form (and all requested supporting documentation) is received by the Plan within 60 days after the expiration of the new deadline period described above. *For example, if you had a qualifying event as described above on May 1, 2020 and the National Emergency ends on June 1, 2020, you will have 60 days from August 1, 2020 (i.e., September 30, 2020) to submit your completed enrollment form and all supporting documentation.*

COBRA Continuation Coverage

- If you or your dependent experience a Qualifying Event (such as your loss of employment or reduction of hours, a dependent spouse's divorce or legal separation, or a child ceasing to qualify as a dependent) the Plan will accept your COBRA election form and consider it to be timely submitted if it is received by the Plan within 60 days after the expiration of the new deadline period described above. *For example, if you or your dependent had a qualifying event as described above on May 1, 2020 and the National Emergency ends on June 1, 2020, you will have 60 days from August 1, 2020 (i.e., September 30, 2020) to submit the completed COBRA election form for coverage purposes.*

- If you or your dependent experience a Qualifying Event, submit a completed COBRA election form and are enrolled for coverage, the monthly COBRA premium you must pay for continuation coverage will be considered timely if received by the Plan within 30 days after the expiration of the new deadline period described above. *For example, if you or your dependent are fully enrolled for COBRA continuation coverage as of May 1, 2020 and the National Emergency ends on June 1, 2020, you will have 30 days from August 1, 2020 (i.e., August 31, 2020) to pay the COBRA premiums owed for May through September, assuming you or your dependent are still enrolled for COBRA continuation coverage in September.*

Filing of Benefit Claims

- In most circumstances, health care providers, dental offices and pharmacies will file claims on your behalf. However, the Plan will now consider a claim to be filed in a timely manner if it is incurred and received at the Plan Office (from you or a provider) within 12 months after the expiration of the new deadline period described above. *For example, if you received medical treatment services on May 1, 2020, and the National Emergency ends on June 1, 2020, you or the provider will have 12 months from August 1, 2020 (i.e., August 1, 2021) to file the claim with the Plan.*

Filing of Disability Claims

- If you become disabled, the Plan will now consider a disability benefit claim to be filed in a timely manner if you notify the Plan of your disability (and submit all required disability benefit forms and supporting documentation) within 30 days after the expiration of the new deadline periods described above. *For example, if you become disabled on May 1, 2020, and the National Emergency ends on June 1, 2020, you will have 30 days from August 1, 2020 (i.e., August 31, 2020) to notify the Plan of your disability and submit all required disability benefit forms and supporting documentation.*

Benefit Claim Appeals and External Review Requests

- If you or your dependent receive an Adverse Benefit Determination by the Plan (with respect to medical benefits, disability benefits or a rescission of coverage) the deadline to file a written appeal with the Plan to dispute the Adverse Benefit Determination will be considered timely if it is received within 180 days after the expiration of the new deadline period described above. *For example, if you received notice of an adverse benefit determination on May 1, 2020, and the National Emergency ends on June 1, 2020, you or your dependent will have 180 days from August 1, 2020 (i.e., January 28, 2021) to file a written appeal with the Plan.*

- In addition, if the Plan denies your appeal (whether in whole or in part) and you receive a Final Adverse Benefit Determination, you or your dependent's request for an external review of the Plan's Final Adverse Benefit Determination - and any subsequent information submitted by your or your dependent to support the request for external review - will be considered timely if it is received within 4 months after the expiration of the new deadline period described above. *For example, you or your dependent filed a written appeal with the Plan on May 1, 2020. You receive a Final Adverse Benefit Determination from the Plan on June 1, 2020. The National Emergency ends on July 1, 2020. Your or your dependent will have 4 months from September 1, 2020 (i.e., January 1, 2021) to file a written request for external review of the Final Adverse Benefit Determination.*

COVID-19 Testing Benefits

In addition to the above deadline extensions, The Plan is also providing the following temporary benefits enhancements for COVID-19 testing for you and your qualified Dependents until December 31, 2020:

- For both in-network and out-of-network providers, the Plan will temporarily cover 100% of the cost of FDA approved in vitro (laboratory) diagnostic products used to detect or diagnose COVID-19 and SARS-COV-2, the virus that causes COVID-19, as well as antibody testing used to identify a previous infection. This coverage will include the costs related to the administration of these in vitro diagnostic products and antibody testing as well. No prior authorization is required.

- For both in-network and out-of-network providers, the Plan will also temporarily cover 100% of the cost of items and services furnished during a health care provider visit, urgent care center visit, and/or emergency room visit (whether it is an in-person or telemed visit) that results in an order for antibody testing, in vitro diagnostic products or administration of in vitro diagnostic products to detect or diagnose COVID-19 and/or SARS-COV-2, the virus that causes COVID-19. No prior authorization is required.

- If you or a covered dependent are tested for COVID-19 and receive a bill to pay, please contact the Fund Office at the number listed below. Please note: Coronavirus testing kits for use at home are not covered.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Plan Description document, contact the Fund Office toll free at 866-732-1919.

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. 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.

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SUMMARY OF MATERIAL MODIFICATIONS
IMPORTANT INFORMATION ABOUT YOUR BENEFITS
in *RELATION TO THE CORONAVIRUS*

APRIL 2020

Dear Plan Participant and Covered Dependent(s):

The Board of Trustees continues to closely monitor events related to the spread of Coronavirus Disease 2019 (COVID-19) and are working hard to develop and expand benefits to further protect you and your family during this pandemic. After significant review, we are pleased to report a number of recently approved benefit enhancements which are described below in greater detail. The Trustees focused on areas of benefit improvement to assist with continued eligibility and new, comprehensive coverages for COVID-19 treatment.

Effective immediately, the Central Illinois Carpenters Health & Welfare Trust Fund (the "Plan") has made the following temporary benefit enhancements through December 31, 2020:

- If you are currently eligible for coverage with the Plan through the March/April/May Benefit Quarter, your coverage will be automatically extended through the June/July/August Benefit Quarter. This eligibility assistance will be provided regardless of the number of hours you worked during the January/February/March Eligibility Quarter.
- The Plan's 15-month eligibility "lookback" period is now reduced from 1,000 hours to 750 hours for the June/July/August and September/October/November Benefit Quarters. This means that if you worked at least 750 hours during the 15-month lookback period to be eligible for these benefit quarters, you will have health insurance coverage during the Benefit Quarter.
- The Plan will now provide you and your family with 100% in-network hospitalization coverage for inpatient COVID-19 treatment. This means that if you or your dependent(s) are hospitalized for COVID-19 treatment, you will have no out-of-pocket costs for these services such as deductibles and coinsurance.

As a reminder, the Plan also covers telemedicine/virtual physician office visits like in-person office visits (deductible and coinsurance). **This means you or your covered dependent may not need to go to a doctor's office which can reduce your exposure to others who are sick and also reduce the spreading of germs if you are sick.** The Plan covers these virtual visits unrelated to the coronavirus so

they are an option for you regardless of your illness. Please contact your doctor to find out more about his/her offering of telemedicine/virtual office visits.

COVID-19 is a new disease and there is more to learn about its transmission, the severity of illness it causes, and to what extent it may spread in the United States. According to the CDC, a person may develop symptoms of the COVID-19 virus within 14 days of exposure. Symptoms include feeling sick with an acute respiratory illness, such as a fever, cough, or difficulty breathing. As there is no present vaccine to prevent COVID-19, the CDC recommends the following to prevent the spread of the virus:

1. Wash hands often with soap and water for at least 20 seconds, and if soap and water are not available, use an alcohol-based hand sanitizer with at least 60% alcohol;
2. Avoid touching eyes, nose, and mouth with unwashed hands;
3. Avoid close contact with people who are sick;
4. Stay home when sick;
5. Cover coughs or sneezes with tissues or cough into the elbow area, then discard the tissue in the trash and follow up with handwashing; and
6. Clean and disinfect frequently touched objects and surfaces regularly

More information about COVID-19 may be found at the following links:

- Centers for Disease Control and Prevention: www.cdc.gov
- Illinois Department of Public Health: http://www.dph.illinois.gov/
- World Health Organization: https://www.who.int

Member Assistance Program is Available FREE of Charge

The stress of world and local events such as the coronavirus can impact your overall health. The Member Assistance Program (MAP) is provided by ComPsych Guidance Resources. This program is free to members and their dependents. Services include counseling, legal and financial consultation and work-life assistance to all members and their household family members (dependents). The program is available 24 hours per day, 365 days a year and is confidential ~ no personal information will be shared with the Plan or its designees.

The MAP is designed to provide short-term counseling services with up to 6 sessions per issue per year. You also have access to a website with information on many topics including relationships, work, school, children, wellness, legal and financial. You may search for local child and elder care, attorneys and financial planners as well as ask questions, take self-assessments and more.

The Plan's web ID is: CIC and then you can register for your own login at guidanceresources.com. The Plan has its own dedicated phone line at 800-272-7255 and you'll speak to a counseling professional who will listen to your concerns and guide you to the appropriate service.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Plan Description document, contact the Fund Office toll free at 866-732-1919.

Sincerely,
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SUMMARY OF MATERIAL MODIFICATIONS
IMPORTANT INFORMATION ABOUT YOUR BENEFITS
in *RELATION TO THE CORONAVIRUS*

MARCH 2020

Dear Participant and Covered Dependent(s):

Because we are concerned for your health and well-being, the Board of Trustees of the Central Illinois Carpenters Health and Welfare Trust Fund (the "Plan") have enhanced the Plan benefits in relation to the Coronavirus (COVID-19).

Testing for the Coronavirus is Covered at 100%

Effective immediately, the Plan will cover 100% of the cost for testing to diagnose COVID-19 when medically necessary and consistent with Centers for Disease Control (CDC) guidance. This means no prior authorization is needed and there is no deductible or coinsurance cost to you for the testing fees.

As long as you, or your qualified dependent, are covered by the Plan on the date of testing, the Plan will pay the cost of testing (administration of test and lab services to process and read the test). If you or a covered dependent are tested for COVID-19 and receive a bill to pay, please contact the Fund Office immediately. Please note: Coronavirus testing kits for use at home are not covered.

Telemedicine/Virtual Physician Office Visits are Covered by the Plan

The Plan covers telemedicine/virtual physician office visits like in-person office visits (deductible and coinsurance). This means you or your covered dependent may not need to go to a doctor's office which can reduce your exposure to others who are sick and also reduce the spreading of germs if you are sick. The Plan covers these virtual visits unrelated to the coronavirus so they are an option for you regardless of your illness. Please contact your doctor to find out more about his/her offering of telemedicine/virtual office visits.

Member Assistance Program is Available

The stress of world and local events such as the coronavirus can impact your overall health. Effects of COVID-19 are seen in cancellations of sporting events and concerts, school closings, reduced/eliminated work schedules and more. The Member Assistance Program (MAP) is provided by ComPsych GuidanceResources. This program is <u>free to members and their dependents</u>. Services

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include counseling, legal and financial consultation and work-life assistance to all members and their household family members (dependents). The program is available 24 hours per day, 365 days a year and is confidential ~ no personal information will be shared with the Plan or its designees.

The MAP is designed to provide short-term counseling services with up to 6 sessions per issue per year. You also have access to a website with information on many topics including relationships, work, school, children, wellness, legal and financial. You may search for local child and elder care, attorneys and financial planners as well as ask questions, take self-assessments and more.

The Plan's web ID is: CIC and then you can register for your own login at guidanceresources.com. The Plan has its own dedicated phone line at 800-272-7255 and you'll speak to a counseling professional who will listen to your concerns and guide you to the appropriate service.

More Information

Please read the enclosed flier from BlueCross BlueShield as it provides helpful information regarding what you can do to stay healthy. The document also lists symptoms of the coronavirus (fever, cough and shortness of breath) and what to do if you think you may have COVID-19.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Plan Description document, contact the Fund Office toll free at 866-732-1919.

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BlueCross BlueShield of Illinois

Coronavirus and What It Means

What is a coronavirus?

Coronaviruses have been around for decades and are perhaps best known for causing illnesses like the common cold, with symptoms like coughing, sneezing and other upper respiratory issues. In late 2019, a new coronavirus was discovered.

What can you do to keep yourself and others healthy?

According to the Centers for Disease Control (CDC):

There is currently no vaccine to prevent coronavirus disease 2019 (COVID-19). The best way to prevent illness is to avoid being exposed to this virus. However, as a reminder, CDC always recommends everyday preventive actions to help prevent the spread of respiratory diseases, including:

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Follow CDC's recommendations for using a facemask.
    - CDC does not recommend that people who are well wear a facemask to protect themselves from respiratory diseases, including COVID-19.
    - Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others.
    - The use of facemasks is also crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

What are the symptoms of the coronavirus?

- Fever
- Cough
- Shortness of breath

What should I do if I think I have COVID-19?

- Seek medical advice if you have recently traveled to a level 3 country as identified by the CDC and feel sick. Please visit https://wwwnc.cdc.gov/travel/notices.
- Call ahead before you go to a doctor's office or emergency room. Tell them about your recent travel and your symptoms.

Do I need to go to the emergency room (ER)?

Not usually. If you are not sure if you need to go to the ER, call your health care provider.

For more information

The CDC is a great resource for up-to-date information about COVID19. Please visit https://www.cdc.gov/coronavirus/2019-ncov/index.html.

* Centers for Disease Control and Prevention: Coronavirus Disease 2019 (COVID19) https://www.cdc.gov/coronavirus/2019-ncov/index.html

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MARCH 2020

Dear Plan Participant and Covered Dependent(s):

With the spread of Coronavirus Disease 2019 (COVID-19) and the recent passage into law of the *Families First Coronavirus Response Act*, your Board of Trustees are closely monitoring events related to COVID-19 and would like to provide this update regarding COVID-19, steps to prevent the spread of the virus, and new benefit enhancements in relation to COVID-19 testing.

Effective March 18, 2020, the Central Illinois Carpenters Health & Welfare Trust Fund (the "Plan") has made the following temporary benefit enhancements through December 31, 2020:

- For both in-network and out-of-network providers, the Plan will temporarily cover 100% of the cost of FDA approved in vitro (laboratory) diagnostic products used to detect or diagnose COVID-19 and SARS-COV-2, the virus that causes COVID-19. This coverage will include the costs related to the administration of these in vitro diagnostic products as well. No prior authorization is required.
- For both in-network and out-of-network providers, the Plan will also temporarily cover 100% of the cost of items and services furnished during a health care provider visit, urgent care center visit, and/or emergency room visit (whether it is an in-person or telemed/virtual visit) that results in an order for in vitro diagnostic products or administration of in vitro diagnostic products to detect or diagnose COVID-19 and/or SARS-COV-2, the virus that causes COVID-19. No prior authorization is required.
- If you or a covered dependent are tested for COVID-19 and receive a bill to pay, please contact the Fund Office at the number listed below. Please note: Coronavirus testing kits for use at home are not covered.

As a reminder, the Plan also covers telemedicine/virtual physician office visits like in-person office visits (deductible and coinsurance). **This means you or your covered dependent may not need to go to a doctor's office which can reduce your exposure to others who are sick and also reduce the spreading of germs if you are sick.** The Plan covers these virtual visits unrelated to the coronavirus so they are an option for you regardless of your illness. Please contact your doctor to find out more about his/her offering of telemedicine/virtual office visits.

The available information about how the virus that causes COVID-19 spread is largely based on what is known about similar coronaviruses. However, COVID-19 is a new disease and there is more to learn about its transmission, the severity of illness it causes, and to what extent it may spread in the United States. According to the CDC, a person may develop symptoms of the COVID-19 virus within 14 days of exposure. Symptoms include feeling sick with an acute respiratory illness, such as a fever, cough, or difficulty breathing. As there is no present vaccine to prevent COVID-19, the CDC recommends the following to prevent the spread of the virus:

1. Wash hands often with soap and water for at least 20 seconds, and if soap and water are not available, use an alcohol-based hand sanitizer with at least 60% alcohol;

2. Avoid touching eyes, nose, and mouth with unwashed hands;

3. Avoid close contact with people who are sick;

4. Stay home when sick;

5. Cover coughs or sneezes with tissues or cough into the elbow area, then discard the tissue in the trash and follow up with handwashing; and

6. Clean and disinfect frequently touched objects and surfaces regularly.

More information about COVID-19 may be found at the following links:

- Centers for Disease Control and Prevention: www.cdc.gov
- Illinois Department of Public Health: http://www.dph.illinois.gov/
- World Health Organization: https://www.who.int

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Plan Description document, contact the Fund Office toll free at 866-732-1919.

Sincerely,

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. 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.

Central Illinois Carpenters Health & Welfare Trust Fund

200 South Madigan Drive, Lincoln, IL 62656
Office Hours: 8:00 am to 4:30 pm Monday-Friday
Phone: 866-732-1919 ~ Website: www.cichealth.org

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IMPORTANT INFORMATION ABOUT YOUR BENEFITS

NOVEMBER 2019

Dear Participant and Covered Dependent(s):

The Trustees of the Central Illinois Carpenters Health and Welfare Trust Fund (the "Plan") have amended the Plan to include the following benefit enhancements for you and your family:

Electric/Powered Wheelchair

Effective September 26, 2019, the Plan now provides each eligible Participant with a $10,000 lifetime maximum benefit for the expense of purchasing an electric/power wheelchair, subject to a determination of medical necessity by the Fund's utilization management vendor.

Crediting of Hours Procedure

The Plan continues to provide all Participants with the ability to have work hours credited for eligibility purposes one (1) time every twelve (12) months for each signatory employer. As of September 26, 2019, any crediting that is made on your behalf under the Crediting of Hours Procedure will not be counted against your one (1) time every twelve (12) month crediting opportunity if the signatory employer pays all outstanding contributions owed, for all employees who are Participants in the Fund, within sixty (60) days of Plan's mailing of quarterly status reports. Please consult your Summary Plan Description for further information regarding the Crediting of Hours Procedure.

OTHER IMPORTANT INFORMATION:

Quarterly Status Report

Your quarterly status report indicates your work hours reported to Fund Office and you should review it to ensure all of your work hours are being reported. You should contact the Fund Office about any discrepancy in hours within 15 days of receiving your report. This report is very important because it states if you are eligible or not for Health Plan benefits. The report is mailed to your address on file at the Fund Office each quarter: i.e. July, August and September hours submitted to the Fund Office by October 31 with report mailed during 1st week of November. **You are responsible to contact the Fund Office if you do not receive your quarterly status report.** Please call the Fund Office with any questions concerning your hours.

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Reciprocal Transfer

If you work out of the area of the Southern Region of the Chicago Regional Council of Carpenters, you will need to contact the Fund Office at 866-732-1919 to obtain a reciprocal (transfer) form to have your hours transferred back to the Central Illinois Carpenters Health and Welfare Trust Fund Office in Lincoln.

New EAP Provider Effective September 1, 2019

The Employee Assistance Program is provided by ComPsych GuidanceResources as of September 1, 2019. This program is free to members and their dependents. Services include counseling, legal and financial consultation and work-life assistance to all members and their household family members (dependents). The program is available 24 hours per day, 365 days a year and is confidential ~ no personal information will be shared with the Plan or its designees.

The EAP is designed to provide short-term counseling services with up to 6 sessions per issue per year. You also have access to a website with information on many topics including relationships, work, school, children, wellness, legal and financial. You may search for local child and elder care, attorneys and financial planners as well as ask questions, take self-assessments and more. The Plan's web ID is: CIC and then you can register for your own login at guidanceresources.com. The Plan has its own dedicated phone line at 800-272-7255 and you'll speak to a counseling professional who will listen to your concerns and guide you to the appropriate service.

Qualifying Events and Family Changes

As a reminder, effective January 1, 2018, the Plan requirement that you provide notice of a qualifying event (such as marriage, divorce, the birth of a child, adoption, placement for adoption of a child or obtaining legal guardianship of a child) to the Fund Office was increased to within 60 days of experiencing the qualifying event in order for you to add a dependent for coverage purposes. As long as the notice requirements are met, and you complete and return the necessary enrollment form and supporting documentation within the required 60-day response timeframe, your dependent's coverage will commence retroactively to the date of the qualifying event.

If you are eligible for benefits and you acquire a dependent through a qualifying event, but fail to notify the Fund Office and/or fail to return a completed enrollment form (including supporting documentation) within the required 60 day timeframe discussed above, you may still seek to enroll the dependent with the Fund Office for coverage to commence as of the date all the documents are received. Contact the Fund Office for more information.

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