North Central States Regional Council of
Carpenters' Benefit Funds
Pension • Health • Supplemental Pension • Training • LMC Trust

P.O. Box 4002 • Eau Claire, WI 54702-4002
715-835-3174 • 800-424-3405 • Fax 715-834-8061 • Claims Fax 715-835-3114

IMPORTANT NOTICE TO PARTICIPANTS

June 2022

To All Active Employees, Pre-Medicare Retirees, and Dependents:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") are pleased to offer a new Diabetes Management Program, through Livongo, a subsidiary of Teledoc Health.

This Program offers eligible Participants and dependents unlimited free glucose testing strips and lancets, a complimentary blood glucose monitor, and real-time interactive coaching access with a number of qualified nutritionists. This Program is completely voluntary, and all supplies and services offered through the Program are covered by the Fund at 100% with no member out-of-pocket expense.

Livongo will be sending out information to those members who might qualify for the Program and who may want to take advantage of all of its offerings to help make managing diabetes easier.

Please keep this Notice with your Summary Plan Description (SPD) booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

NCSRCC\not\2022\Livongo Diabetes Program June 2022

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IMPORTANT NOTICE TO PARTICIPANTS

June 2022

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

This SMM reflects Trustee action to amend the coordination of benefits rules to provide that the Plan will coordinate with individual policies, effective March 1, 2022.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

The following changes are effective March 1, 2022:

The **COORDINATION OF BENEFITS WITH OTHER PLANS** section beginning on page 71 of the SPD is amended to amend the second paragraph to read as follows:

> If you or your eligible Dependents are entitled to benefits under any Other Plan, the amount of benefits payable by this Plan will be coordinated so that the aggregate amount paid will not exceed 100% of the health care expenses incurred. In no event will this Plan's payment exceed the amount which would have been paid if there were no other plan involved. Benefits payable under another plan include the benefits that would have been payable even if no claim actually was filed with the other plan.

Subsections 1. and 2. of the *Definitions for this Coordination of Benefits Provision* section beginning on page 71 of the SPD are amended to read as follows:

> *Definitions for this Coordination of Benefits Provision*
>
> 1. “Other Plan” will mean any plan providing benefits or services for or by reason of medical, dental, or vision care under: group insurance; group practice, Blue Cross, Blue Shield, or other prepayment coverage; labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; governmental employees group programs, including Medicare, or coverage required or provided by law; individual insurance policy; or automobile reparation (no-fault) insurance required under any applicable law and provided through arrangements other than a court decree establishing financial responsibility for medical expenses, but only to the extent of benefits required under such no-fault insurance law.
>
> 2. The term “Other Plan” will be construed separately as to each policy, contract, or other arrangement for benefits or services and separately as to any part which may consider benefits or services of other plans in determining its benefits and any part which does not. An individual may have other health plan coverage containing a provision, or some similar provision whose purpose is to provide primary coverage only for a small amount of expenses, well below the maximum benefit available under the plan if no other coverage is available (collectively, a “sub-plan provision”). The effect or intent of a plan with a sub-plan provision is to transfer the much larger secondary coverage to the other health plan with which such plan is coordinating benefits. In the event this Plan is coordinating benefits with a plan containing a sub-plan provision, the sub-plan provision will be treated as arbitrary and capricious and a subterfuge and will be ignored, resulting in coordination of benefits with the plan, sub-plan, or similar provision that would apply if the Eligible Person did not have coverage under this Plan.

The *Order of Benefit Calculation* section beginning on page 72 of the SPD is amended to replace the first paragraph to read as follows:

> *Order of Benefit Calculation.* In the case of duplicate group or individual coverage for an Eligible Person, you must report such duplicate group or individual health plan coverage. If another plan or portion of a plan covering the Eligible Person does not contain a coordination of benefits provision, then that plan must determine the benefits it pays before this Plan does.

Rule number 1 under the third paragraph is also amended to read as follows:

> 1. If a person is eligible as an employee or policyholder in one plan and as a Dependent in another (unless otherwise mandated by Medicare), the plan covering the person as an employee or policyholder is primary.

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IMPORTANT NOTICE TO PARTICIPANTS

March 2022

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

This SMM reflects a number of recent Trustee actions:

- Effective January 1, 2022, the SPD is amended to clarify prior authorization requirements for laboratory sleep studies; increase the CPAP, BiPAP, and AutoPAP supplies maximum; and cover replacement crowns after a five-year period from the date of placement;

- Effective January 15, 2022, the SPD is amended to provide temporary coverage for over-the-counter COVID-19 tests; and

- Effective May 1, 2022, the SPD is amended to revise the hours requirements for initial eligibility.

The Trustees also amended the SPD to implement changes required by a Federal statute, the No Surprises Act (which Congress passed as part of the Consolidated Appropriations Act, 2021). All of the No Surprises Act changes are effective January 1, 2022. The changes required under the No Surprises Act are also reflected in the attached SMM.

The No Surprises Act includes rules to protect you from surprise balance billing (balance bills are what non-network providers or facilities can charge you even if after you pay your deductible, copayment or coinsurance – also known as your "cost-sharing" amounts). Under these new rules, non-network providers can no longer send you these surprise balance bills in the following situations:

- Emergency services (not including ground ambulance services) from a non-network provider, facility, or air ambulance. This includes services you receive after you are in stable condition.

- When you receive certain services, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon services, hospitalist services, or intensivist services, from a non-network provider at a network hospital or ambulatory surgical center.

When balance billing is not allowed:

- You will pay only network cost-sharing amounts.
- Your cost-sharing amounts will be based on what the Fund would pay for the services had they been provided by a network provider.
- What you pay will count toward your network deductible and out-of-pocket limit.
- If the Fund denies a claim for a service protected from balance billing, you can submit the claim for external review at the end of the Fund's appeal process.

Don't accidentally give up your protections against balance billing!
Read any consents you are given before you receive health care.

Non-network providers can ask you to give up your balance billing protections for post-stabilization services and other services you may receive from a non-network provider at a network hospital or ambulatory surgical center.

In addition to the balance billing protection, the No Surprises Act also provides the following protections for you:

- If a network provider or facility leaves the Anthem network, you may be able to receive care as if the provider or facility was still a network provider for up to 90 days so that you have time to transition to a network provider. You will have this option if you are inpatient, scheduled for nonelective surgery, or receiving care for a pregnancy, serious and complex condition, or terminal illness when your provider or facility leaves the Anthem network. Contact the Fund Office for more information if you think this may apply to you.
- If you can show that you received inaccurate information from Anthem that a provider was a network provider, then you will pay network cost-sharing for that claim. However, note that the non-network provider may still balance bill you for that claim.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

The following changes are effective January 1, 2022:

Footnote 3 of the **COMPREHENSIVE MAJOR MEDICAL BENEFITS** section of the Schedule of Benefits found on page v of your SPD is revised as follows:

> [3] All Protected Services will be payable at the in-network level of benefits .

The **CPAP, BiPAP, and AutoPAP supplies** section of the **COMPREHENSIVE MAJOR MEDICAL BENEFITS** section of the Schedule of Benefits for Classes C and O for Active Employees and Dependents on page viii of the SPD is amended to read:

CPAP, BiPAP, and AutoPAP supplies (Preauthorization recommended)	$400 maximum per Eligible Person per Calendar Year

The **Preauthorization and Precertification Requirements** section beginning on page xviii of the SPD is amended to replace the ***Diagnostics*** subsection to read as follows:

> ***Diagnostics:***
> - Amniocentesis if under the age of 35.
> - Genetic testing.
> - Neuropsychological testing/assessments.
> - Laboratory sleep studies.
> - MRIs (including breast MRIs) and CT scans of the brain.

The ***Sleep Disorders*** section on page 34 of the SPD is amended to read:

> ***Sleep Disorders***. Benefits are payable for costs related to sleep studies conducted in a licensed sleep lab or for home sleep studies, provided certain conditions are satisfied. Written guidelines are maintained by CMS. Preauthorization is recommended for laboratory sleep studies (see page xviii).

The ***Basic and Major Services*** section under the **Dental Plan 1 – Delta Dental of Wisconsin** section beginning on page 45 of the SPD is amended to replace subsection (j)(3) to read as follows:

> (3) Coverage for the purpose of replacing a defective existing crown, inlay, onlay, fixed bridge, or partial/complete denture will be provided only after a five-year period from the date on which it was last supplied.

The **PREFERRED PROVIDER NETWORK** section beginning on page 52 of your SPD is revised to add a new paragraph:

> If a provider or facility leaves the Preferred Provider Network or otherwise becomes a non-network provider while you are receiving, or scheduled to receive, services from the provider or facility, you may be able to continue receiving care from the provider or facility as if they were still in the network for up to 90 days so that you

have time to transition to a new Preferred Provider. Contact the Fund Office for more details.

The **GENERAL DEFINITIONS** section beginning on page 85 of your SPD is revised to add a few new definitions, and to revise an existing definition. These new/revised definitions read as follows:

Emergency Medical Condition means a condition that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care.

Emergency Services means services for or in response to an Emergency Medical Condition, including any medical examination and treatment necessary to evaluate and stabilize the patient and any post-stabilization services rendered to a patient admitted through a Hospital or Freestanding Emergency Center or as part of outpatient observation.

Emergency Services generally include all services that are part of the same visit in which an Emergency Medical Condition is treated. However, post-stabilization services that meet the following requirements shall not be considered Emergency Services:

1. The attending physician determines that the patient is able to travel using nonmedical or nonemergency medical transportation to an available network provider located within a reasonable distance;

2. The provider/facility providing the services satisfies the notice and consent requirements under the No Surprises Act;

3. The patient (or a person authorized by law to provide consent on behalf of the patient) is in a condition to receive the required notice under the No Surprises Act and provide informed consent; and

4. The provider/facility satisfies any additional requirements or prohibitions required by state law.

Freestanding Emergency Center means a facility that is geographically distinct and licensed separately from a Hospital and that is licensed under state law to provide Emergency Services, regardless of how the facility is classified.

No Surprises Act means the No Surprises Act portion of the Consolidated Appropriations Act, 2021, its implementing regulations and other underlying guidance.

Protected Services means:

1. Emergency Services furnished by a non-network provider;

2. Air ambulance services furnished by a non-network provider;

3. Non-emergency items and services, such as anesthesiology, pathology, radiology, diagnostic services, and other services defined as ancillary services under the No Surprises Act furnished by a non-network provider at a network facility; and

4. Other non-emergency items and services furnished by a non-network provider at a network Hospital, Hospital outpatient department, critical access Hospital, or ambulatory surgical center if (a) such items and services would be covered by the Plan if furnished by a network provider and (b) the provider does not satisfy the notice and consent requirements under the No Surprises Act.

Reasonable Expense means the charges incurred for services and supplies which are Medically Necessary for treatment and which are "regular and customary." "Regular and customary charges" will be determined as follows:

1. With respect to a Preferred Provider, the applicable charge under the Preferred Provider's agreement with the Trustees.

2. With respect to any provider that does not qualify as a Preferred Provider located within the geographic area served by the Preferred Provider Network, the amount the Fund would have paid to a Preferred Provider for the same service or supply.

3. With respect to a provider outside the geographic area served by the Preferred Provider Network, the amount, as determined by the Trustees or their designee, to be the lowest of:

    a. the usual charge by the Physician for the same or similar service or supply, as determined by the Preferred Provider; or

    b. the Physician's actual charge.

4. For Protected Services, the amount required under the No Surprises Act.

The first paragraph of the **Federal External Claims Review Process – Rescissions and Health Claims Other than Dental and Vision Only** section on page 108 of your SPD is revised as follows:

> If the Plan has denied your health claim and issued you an adverse benefit determination under the internal claims appeal procedures, you may have the right to appeal your decision externally. Only health claims that involve medical judgment or the balance billing protections of the No Surprises Act, or a rescission of coverage are eligible for external review. Dental, vision, Accident and Sickness Weekly Benefit, death, and accidental death and dismemberment benefit claims are not eligible for external review.

The following changes are effective January 15, 2022:

The **Temporary COVID-19 Benefits** section of the benefit schedule for Active and Retiree Classes beginning on page x of the SPD is amended to read as follows:

Temporary COVID-19 Benefits	
Qualifying COVID-19 Testing	100%
Office visits (including telehealth), urgent care visits and emergency room visits that result in administration or ordering of a COVID-19 test	100%
COVID-19 related preventive care services provided by an out-of-network provider	100%
FDA-approved, cleared, or authorized over-the-counter COVID-19 tests (maximum 8 tests per Eligible Person per 30-day period)	
In-network Pharmacy (including mail order)	100%
Out-of-network Pharmacy or other vendor	Lesser of actual cost or $12

The ***Other Covered Charges*** section beginning on page 32 of the SPD is amended to add a new subsection 11. to read as follows:

11. FDA-approved, cleared or authorized over-the-counter (OTC) COVID-19 tests purchased by an Eligible Individual on and after January 15, 2022 through the end of the public health emergency, with no prior authorization or medical management requirements (except as specifically noted) consistent with the Families First Coronavirus Response Act or other applicable Federal law. The Plan will cover 8 tests per Eligible Individual per 30-day period. Testing kits with 2 tests in the box count as 2 tests toward this limit.

    The Plan will not cover OTC COVID-19 tests:

    a. used for employment purposes;

    b. purchased for purposes of resale;

    c. purchased prior to January 15, 2022;

    d. purchased using a flexible spending account, health reimbursement arrangement (including the HRA Program) or health spending account.

The following change is effective May 1, 2022:

The **RULE I. INITIAL ELIGIBILITY** section beginning on page 2 of the SPD is amended to read:

Bargaining Unit Employees, Non-Bargaining Unit Employees, and Alumni

You and your Dependents become initially eligible on the first day of the second month following the month in which you have worked and are credited with at least

390 hours of contributions at the Prevailing Contribution Rate as shown in the following chart. Hours spent in the classroom of any Training Center in the North Central States Regional Council of Carpenters' jurisdiction are considered hours for eligibility. Hours contributed at less than the Prevailing Contribution Rate will be prorated. Such contributions must be credited within 12 consecutive months.

390th Hour Worked During	Contributions Received During	Initial Eligibility Begins
January	February	March 1
February	March	April 1
March	April	May 1
April	May	June 1
May	June	July 1
June	July	August 1
July	August	September 1
August	September	October 1
September	October	November 1
October	November	December 1
November	December	January 1
December	January	February 1

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♦♦ IMPORTANT NOTICE TO PARTICIPANTS ♦♦

March 2022

To All Participants and Dependents:

This Notice is to inform you of the following:

- ♦ Change to the Health Plan
- ♦ Women's Health and Cancer Rights Act Annual Notification
- ♦ HIPAA Privacy Update

Plan Change

The Board of Trustees ("Trustees") of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modification ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

This SMM reflects the Trustee's action to:

- Eliminate the second internal level of appeal to the Executive Committee of the Board of Trustees.

- Increase the period of time in which the Eligibility and Appeals Committee must notify you of a decision reviewing your appeal of a pre-service claim denial to 30 days after receiving your appeal request.

- Change the periods of time in which the Eligibility and Appeals Committee must reach a decision reviewing your appeal of an adverse decision on a post-service medical claim, Accident and Sickness Weekly Benefit Claim or Death Benefit and Accidental Death and Dismemberment Benefit claim and notify you of the decision.

Annual Notification of Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires the North Central States Regional Council of Carpenters Health Plan (the "Plan") to notify you, as a participant or beneficiary of the Plan, of your rights related to Plan benefits provided in connection with a mastectomy. For covered individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient for:

- »» All stages of reconstruction of the breast on which the mastectomy was performed;
- »» Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- »» Prostheses; and
- »» Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan. For further details on coverage for these benefits, please refer to your Summary Plan Description.

HIPAA Privacy Update

On April 14, 2003, the HIPAA Privacy Regulations went into effect for the North Central States Regional Council of Carpenters' Health Fund. These Regulations were further revised effective February 17, 2010, and again revised effective September 23, 2013. In September of 2016 (or when you enrolled, if later), the Plan provided you an updated Privacy Practices Notice as required by the Privacy Regulations. This Notice provided information regarding the Plan's uses and disclosures of your Protected Health Information (PHI), your rights regarding your PHI, and the Plan's duties to protect the privacy of your PHI.

This is a reminder that the Plan's Privacy Practices Notice is available upon request. To request a copy, please contact the Fund's Privacy Officer at: (715) 835-3174 or 1-800-424-3405.

Other Enclosures

Also enclosed with this Notice is the Annual Notice Regarding Medicaid and the Children's Health Insurance Program (CHIP) Offer for Free or Low-Cost Health Coverage to Children and Families

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call or write to the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modification

Effective for claims received by the Plan on and after April 1, 2022, the SPD is amended to make the following changes:

1. The paragraph numbered 1 in the Internal Claims and Appeal Procedures on page 104 of the SPD is amended to read as follows:

1. The Plan has two levels of appeal for health care claims (other than dental and vision). The first level of appeal is decided by the Eligibility and Appeals Committee of the Trustees. The optional second level is the Federal External Claims Review Process and is decided by an Independent Review Organization (IRO). The rules regarding claims appeal procedures apply to the first level of appeal, while the optional Federal External Claims Review Process has its own independent appeal procedure.

2. The paragraphs numbered 10, 11 and 12 in the **Internal Claims Appeal Procedures** on page 105 of the SPD are amended to read as follows:

10. For appeals of pre-service claims, the Plan will notify you of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days of the Plan's receipt of your appeal request.

11. For appeals of post-service claims adverse benefit determinations, the Plan will make decision no later than the date of the meeting of the Eligibility and Appeals Committee that immediately follows the Plan's receipt of your appeal request, unless the request is filed within 30 days preceding the date of the meeting. In such case, a decision will be made by no later than the date of the second Eligibility and Appeals Committee meeting following the Plan's receipt of your appeal request. If special circumstances require a further extension of time for processing, a decision will be rendered not later than the third meeting of the Eligibility and Appeals Committee following the Plan's receipt of your appeal request. If such an extension of for review is required because of special circumstances, the Plan shall notify you in writing of the extension, describing the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. You will be notified of the decision within 5 days after the decision is made.

12. For appeals of Accident and Sickness Weekly Benefit claims, and Death Benefit and Accidental Death and Dismemberment Benefit adverse benefit determinations, the Plan will make a decision no later than the date of the meeting of the Eligibility and Appeals Committee that immediately follows the Plan's receipt of your appeal request, unless the request is filed within 30 days preceding the date of the meeting. In such case, a decision will be made by no later than the date of the second Eligibility and Appeals Committee meeting following the Plan's receipt of your appeal request. If special circumstances require a further extension of time for processing, a decision will be rendered not later than the third meeting of the Eligibility and Appeals Committee following the Plan's receipt of your appeal request. If such an extension of for review is required because of special circumstances, the Plan shall notify you in writing of the extension, describing the special circumstances and the date as of which the

decision will be made, prior to the commencement of the extension. You will be notified of the decision within 5 days after the decision is made.

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March 2022

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The Trustees also amended the SPD to implement changes required by a Federal statute, the No Surprises Act (which Congress passed as part of the Consolidated Appropriations Act, 2021). All of the No Surprises Act changes are effective January 1, 2022. The changes required under the No Surprises Act are also reflected in the attached SMM.

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- When you receive certain services, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon services, hospitalist services, or intensivist services, from a non-network provider at a network hospital or ambulatory surgical center.

When balance billing is not allowed:

- You will pay only network cost-sharing amounts.
- Your cost-sharing amounts will be based on what the Fund would pay for the services had they been provided by a network provider.
- What you pay will count toward your network deductible and out-of-pocket limit.
- If the Fund denies a claim for a service protected from balance billing, you can submit the claim for external review at the end of the Fund's appeal process.

Don't accidentally give up your protections against balance billing!
Read any consents you are given before you receive health care.

Non-network providers can ask you to give up your balance billing protections for post-stabilization services and other services you may receive from a non-network provider at a network hospital or ambulatory surgical center.

In addition to the balance billing protection, the No Surprises Act also provides the following protections for you:

- If a network provider or facility leaves the Anthem network, you may be able to receive care as if the provider or facility was still a network provider for up to 90 days so that you have time to transition to a network provider. You will have this option if you are inpatient, scheduled for nonelective surgery, or receiving care for a pregnancy, serious and complex condition, or terminal illness when your provider or facility leaves the Anthem network. Contact the Fund Office for more information if you think this may apply to you.
- If you can show that you received inaccurate information from Anthem that a provider was a network provider, then you will pay network cost-sharing for that claim. However, note that the non-network provider may still balance bill you for that claim.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

The following changes are effective January 1, 2022:

Footnote 3 of the **COMPREHENSIVE MAJOR MEDICAL BENEFITS** section of the Schedule of Benefits found on page v of your SPD is revised as follows:

> [3] All Protected Services will be payable at the in-network level of benefits .

The **CPAP, BiPAP, and AutoPAP supplies** section of the **COMPREHENSIVE MAJOR MEDICAL BENEFITS** section of the Schedule of Benefits for Classes C and O for Active Employees and Dependents on page viii of the SPD is amended to read:

CPAP, BiPAP, and AutoPAP supplies (Preauthorization recommended)	$400 maximum per Eligible Person per Calendar Year

The **Preauthorization and Precertification Requirements** section beginning on page xviii of the SPD is amended to replace the ***Diagnostics*** subsection to read as follows:

> ***Diagnostics:***
> - Amniocentesis if under the age of 35.
> - Genetic testing.
> - Neuropsychological testing/assessments.
> - Laboratory sleep studies.
> - MRIs (including breast MRIs) and CT scans of the brain.

The ***Sleep Disorders*** section on page 34 of the SPD is amended to read:

> ***Sleep Disorders***. Benefits are payable for costs related to sleep studies conducted in a licensed sleep lab or for home sleep studies, provided certain conditions are satisfied. Written guidelines are maintained by CMS. Preauthorization is recommended for laboratory sleep studies (see page xviii).

The ***Basic and Major Services*** section under the **Dental Plan 1 – Delta Dental of Wisconsin** section beginning on page 45 of the SPD is amended to replace subsection (j)(3) to read as follows:

> (3) Coverage for the purpose of replacing a defective existing crown, inlay, onlay, fixed bridge, or partial/complete denture will be provided only after a five-year period from the date on which it was last supplied.

The **PREFERRED PROVIDER NETWORK** section beginning on page 52 of your SPD is revised to add a new paragraph:

> If a provider or facility leaves the Preferred Provider Network or otherwise becomes a non-network provider while you are receiving, or scheduled to receive, services from the provider or facility, you may be able to continue receiving care from the provider or facility as if they were still in the network for up to 90 days so that you

have time to transition to a new Preferred Provider. Contact the Fund Office for more details.

The **GENERAL DEFINITIONS** section beginning on page 85 of your SPD is revised to add a few new definitions, and to revise an existing definition. These new/revised definitions read as follows:

Emergency Medical Condition means a condition that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care.

Emergency Services means services for or in response to an Emergency Medical Condition, including any medical examination and treatment necessary to evaluate and stabilize the patient and any post-stabilization services rendered to a patient admitted through a Hospital or Freestanding Emergency Center or as part of outpatient observation.

Emergency Services generally include all services that are part of the same visit in which an Emergency Medical Condition is treated. However, post-stabilization services that meet the following requirements shall not be considered Emergency Services:

1. The attending physician determines that the patient is able to travel using nonmedical or nonemergency medical transportation to an available network provider located within a reasonable distance;

2. The provider/facility providing the services satisfies the notice and consent requirements under the No Surprises Act;

3. The patient (or a person authorized by law to provide consent on behalf of the patient) is in a condition to receive the required notice under the No Surprises Act and provide informed consent; and

4. The provider/facility satisfies any additional requirements or prohibitions required by state law.

Freestanding Emergency Center means a facility that is geographically distinct and licensed separately from a Hospital and that is licensed under state law to provide Emergency Services, regardless of how the facility is classified.

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Protected Services means:

1. Emergency Services furnished by a non-network provider;

2. Air ambulance services furnished by a non-network provider;

3. Non-emergency items and services, such as anesthesiology, pathology, radiology, diagnostic services, and other services defined as ancillary services under the No Surprises Act furnished by a non-network provider at a network facility; and

4. Other non-emergency items and services furnished by a non-network provider at a network Hospital, Hospital outpatient department, critical access Hospital, or ambulatory surgical center if (a) such items and services would be covered by the Plan if furnished by a network provider and (b) the provider does not satisfy the notice and consent requirements under the No Surprises Act.

Reasonable Expense means the charges incurred for services and supplies which are Medically Necessary for treatment and which are "regular and customary." "Regular and customary charges" will be determined as follows:

1. With respect to a Preferred Provider, the applicable charge under the Preferred Provider's agreement with the Trustees.

2. With respect to any provider that does not qualify as a Preferred Provider located within the geographic area served by the Preferred Provider Network, the amount the Fund would have paid to a Preferred Provider for the same service or supply.

3. With respect to a provider outside the geographic area served by the Preferred Provider Network, the amount, as determined by the Trustees or their designee, to be the lowest of:

    a. the usual charge by the Physician for the same or similar service or supply, as determined by the Preferred Provider; or

    b. the Physician's actual charge.

4. For Protected Services, the amount required under the No Surprises Act.

The first paragraph of the **Federal External Claims Review Process – Rescissions and Health Claims Other than Dental and Vision Only** section on page 108 of your SPD is revised as follows:

> If the Plan has denied your health claim and issued you an adverse benefit determination under the internal claims appeal procedures, you may have the right to appeal your decision externally. Only health claims that involve medical judgment or the balance billing protections of the No Surprises Act, or a rescission of coverage are eligible for external review. Dental, vision, Accident and Sickness Weekly Benefit, death, and accidental death and dismemberment benefit claims are not eligible for external review.

The following changes are effective January 15, 2022:

The **Temporary COVID-19 Benefits** section of the benefit schedule for Active and Retiree Classes beginning on page x of the SPD is amended to read as follows:

Temporary COVID-19 Benefits	
Qualifying COVID-19 Testing	100%
Office visits (including telehealth), urgent care visits and emergency room visits that result in administration or ordering of a COVID-19 test	100%
COVID-19 related preventive care services provided by an out-of-network provider	100%
FDA-approved, cleared, or authorized over-the-counter COVID-19 tests (maximum 8 tests per Eligible Person per 30-day period)	
In-network Pharmacy (including mail order)	100%
Out-of-network Pharmacy or other vendor	Lesser of actual cost or $12

The ***Other Covered Charges*** section beginning on page 32 of the SPD is amended to add a new subsection 11. to read as follows:

11. FDA-approved, cleared or authorized over-the-counter (OTC) COVID-19 tests purchased by an Eligible Individual on and after January 15, 2022 through the end of the public health emergency, with no prior authorization or medical management requirements (except as specifically noted) consistent with the Families First Coronavirus Response Act or other applicable Federal law. The Plan will cover 8 tests per Eligible Individual per 30-day period. Testing kits with 2 tests in the box count as 2 tests toward this limit.

    The Plan will not cover OTC COVID-19 tests:

    a. used for employment purposes;

    b. purchased for purposes of resale;

    c. purchased prior to January 15, 2022;

    d. purchased using a flexible spending account, health reimbursement arrangement (including the HRA Program) or health spending account.

The following change is effective May 1, 2022:

The **RULE I. INITIAL ELIGIBILITY** section beginning on page 2 of the SPD is amended to read:

Bargaining Unit Employees, Non-Bargaining Unit Employees, and Alumni

You and your Dependents become initially eligible on the first day of the second month following the month in which you have worked and are credited with at least

390 hours of contributions at the Prevailing Contribution Rate as shown in the following chart. Hours spent in the classroom of any Training Center in the North Central States Regional Council of Carpenters' jurisdiction are considered hours for eligibility. Hours contributed at less than the Prevailing Contribution Rate will be prorated. Such contributions must be credited within 12 consecutive months.

390th Hour Worked During	Contributions Received During	Initial Eligibility Begins
January	February	March 1
February	March	April 1
March	April	May 1
April	May	June 1
May	June	July 1
June	July	August 1
July	August	September 1
August	September	October 1
September	October	November 1
October	November	December 1
November	December	January 1
December	January	February 1

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IMPORTANT NOTICE TO PARTICIPANTS

December 2021

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

Briefly, this SMM reflects recent Trustee action to:

- Provide that during partial weeks of disability, Participants will be paid at the daily rate of one-fifth of the weekly benefit rate per day; and

- Allow Accident and Sickness Weekly Benefits to be paid without the certification by a medical professional for up to two days for COVID-19 vaccine side effects, provided you demonstrate you received a COVID-19 vaccine.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

Effective December 7, 2021, the SPD is amended to make the following changes:

1. The **ACCIDENT AND SICKNESS WEEKLY BENEFITS** section beginning on page 58 of the SPD is amended to read as follows:

When you are determined to be totally disabled by Trustees, based upon certification by a Physician, Chiropractor, or doctor of dental surgery (D.D.S.), Accident and Sickness Weekly Benefits will be paid to you at the weekly benefit rate and up to the maximum number of weeks payable during any disability as specified in the Schedule of Benefits during periods in which you have not been approved by your treating Physician, Chiropractor or doctor of dental surgery to return to your own occupation in Covered Work. During partial weeks of disability, you will be paid at the daily rate of one-fifth of the weekly benefit rate for each day you are disabled. Benefits are payable for disabilities due to nervous and mental disorders, alcoholism, and substance use disorder only while Hospital-confined and limited as specified in the Schedule of Benefits. The weekly benefit rate for a pregnancy and/or post delivery-related disability is payable to a mother during pregnancy and/or following childbirth as specified in the Schedule of Benefits.

However, if you are absent from active work because of Injury or Sickness on the effective date of your coverage under the Plan, you will not be eligible for Accident and Sickness Weekly Benefits until the disability ends and you return to full-time active work as defined later in this section.

Benefits begin on the first day of disability due to an Injury or the eighth day of disability due to Sickness. For the purposes of Accident and Sickness Weekly Benefits, only your absence from work which immediately follows the date of the original Injury will be considered for benefits on the first day of the disability. Related symptoms and recurrent symptoms of the Injury will be considered a disability caused by a Sickness and considered for Accident and Sickness Weekly Benefits beginning on the eighth day of the disability. Effective December 7, 2021, benefits will be provided for up to two days following receipt of a COVID-19 vaccine if side effects caused by the vaccine prevent you from working without the need to produce a certification from a medical professional that you are totally disabled, provided you demonstrate you received a COVID-19 vaccine.

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IMPORTANT NOTICE TO PARTICIPANTS

November 2021

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

Briefly, this SMM reflects recent Trustee action to:

- Remove the $200 limit for well child care charges for Dependent children ages two and over.
- Cover well child care routine examinations and laboratory tests recommended by the American Academy of Pediatrics for Dependent children from birth to age 18.
- Modify the Vision Benefits available for Active and Optional Retiree Classes under the Anthem BlueCross BlueShield Vision Plan.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

Effective January 1, 2022, the SPD is amended to make the following changes:

1. The **COMPREHENSIVE MAJOR MEDICAL BENEFITS** section of the **Schedule of Benefits for Active Employees and Dependents (Classes C and O)** beginning on page vi of the SPD is amended to read as follows:

> Well child care, 100% of Reasonable Expenses for: routine examinations and laboratory tests recommended by the American Academy of Pediatrics from birth to age 18.

2. The **VISION CARE BENEFITS** section of the **Schedule of Benefits for Active and Optional Retiree Classes (Classes C, G, O, P, S, and T)** beginning on page ix of the SPD is amended to read as follows:

Classes C, G, O, P, S, and T **For Active and Optional Retiree Classes** **VISION CARE BENEFITS**		
	In-Network Provider	Non-Network Provider
Routine Eye Exam Limited to one per calendar year	$0	Up to $50 allowance
Prescription Glasses Each Eligible Person will receive an allowance toward the purchase of an eyeglass frame, lenses and lens options of their choice once every two calendar years.		
Eyeglass frame lenses and lens option	$350 allowance then 20% off any remaining balance.	$350 allowance
Prescription Contact Lenses[1] Available once every two calendar years		
Elective conventional (non-disposable) contact lenses	$350 allowance then 15% off any remaining balance	$350 allowance
Elective disposable contact lenses	$350 allowance (no additional discount)	$350 allowance
Medically necessary contact lenses	Covered in full	$350 allowance
If you receive covered eyewear from a Blue View Vision provider, you may be eligible for additional discounts on vision benefits such as lens enhancements, additional glasses, contact lens fittings, LASIK surgery.		

[1] Contact lenses are in lieu of your eyeglass lens benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this Schedule of Benefits.

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IMPORTANT NOTICE TO PARTICIPANTS

September 2021

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

Briefly, this SMM reflects recent Trustee action to:

- Provide additional coverage for breast pumps.
- Clarify guardianship coverage
- Clarify Accident and Sickness Weekly Benefits coverage

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

The SPD is amended to provide coverage for one breast pump per live birth, to clarify guardianship coverage, and to clarify that Accident and Sickness Weekly Benefits coverage will be provided for Participants unable to perform work covered by a collective bargaining agreement, effective as of the dates set forth below. The following changes are made to the SPD:

1. Effective January 1, 2021, the ***When Obtained at a Preferred Provider*** section under the **PREVENTIVE CARE** section beginning on page 36 of the SPD is amended to replace subsection 4b. to read as follows:

> 4. With respect to women, evidence-informed preventive care and screening as provided for in the comprehensive guidelines supported by HRSA, with the following limitations:
>
> a. contraception in each FDA-approved contraception method is covered under this preventive care benefit, except those methods covered under the PPRx.
>
> b. Purchase of electric or manual breast pump is limited to one pump per live birth.

2. Effective January 1, 2021, the definition of **Dependent** under the **General Definitions** section is amended to add a new subsection f on page 89 under "Other Dependents" to read as follows:

> f. Children for whom the Eligible Employee or the Eligible Employee's Spouse was awarded permanent legal guardianship by a court of competent jurisdiction. The child must be under age 19, or under age 23 as long as their primary activity is that of a full-time student (carrying at least 12 credits) enrolled in and attending classes at an accredited school. The child must: receive more than one-half of their annual support from you, be unmarried, and have the same principal residence as you for more than one-half of the Calendar Year except for temporary absences. A child who is 19 or older and under age 23 must verify school enrollment on Plan forms. However, if the child loses full-time status while covered under the Plan due to a Medically Necessary leave of absence, as certified in writing by a Physician, the child will remain eligible under the Plan in accordance with ERISA section 714 and Code Section 9813 (known as Michelle's law). On an annual basis, the Trustees may require you to submit documentation showing a child covered under this subsection meets all of the above criteria. Failure to timely provide the requested documentation may result in loss of the Dependent status for the child.

3. Effective September 1, 2021, the **ACCIDENT AND SICKNESS WEEKLY BENEFITS** section beginning on page 58 of the SPD is amended to read as follows:

When you are determined to be totally disabled by Trustees based upon certification by a Physician, Chiropractor, or doctor of dental surgery (D.D.S.), Accident and Sickness Weekly Benefits will be paid to you at the weekly benefit rate and up to the maximum number of weeks payable during any disability as specified in the Schedule of Benefits during periods in which you have not been approved by your treating Physician, Chiropractor or doctor of dental surgery to return to your own occupation in Covered Work. During partial weeks of disability, you will be paid at the daily rate of one-seventh of the weekly benefit rate for each day you are disabled. Benefits are payable for disabilities due to nervous and mental disorders, alcoholism, and substance use disorder only while Hospital-confined and limited as specified in the Schedule of Benefits. The weekly benefit rate for a pregnancy and/or post delivery-related disability is payable to a mother during pregnancy and/or following childbirth as specified in the Schedule of Benefits.

Additionally, the **ACCIDENT AND SICKNESS WEEKLY BENEFITS** section of the Schedule of Benefits for Classes C and O beginning on page xi of the SPD is amended to read as follows:

Classes C and O For Active Employees Only	
DEATH BENEFITS	
Amount of Death Benefit	$20,000
Principal Sum for Accidental Death and Dismemberment	$20,000
ACCIDENT AND SICKNESS WEEKLY BENEFITS	
Weekly benefit rate	$450
Maximum number of weeks payable per disability Benefits will continue until the date you are able to return to your regular occupation in Covered Work. Accident and Sickness Weekly Benefits are limited to 10 days per Eligible Employee per Calendar Year for treatment of nervous and mental disorders while Hospital-confined and 30 days per each Eligible Employee's Lifetime for treatment of alcoholism and substance abuse while Hospital-confined. Benefits begin on the first day of a disability caused by an Injury and on the eighth day of a disability caused by a Sickness. Effective March 18, 2020 until the U.S. Department of Health and Human Services declares the	26

COVID-19 health emergency has ended, there will be no waiting period for a disability caused by a Sickness. An $800 per week pregnancy and post-delivery Accident and Sickness Weekly Benefit is available for mothers who are disabled while pregnant and/or following delivery of a child for a maximum of 26 weeks. The pregnancy and post-delivery Accident and Sickness Weekly Benefit is available during pregnancy for a pregnancy-related condition resulting in disability. Following childbirth, up to six weeks of post-delivery benefits are payable under the pregnancy and post-delivery Accident and Sickness Weekly Benefit (up to eight weeks for Cesarean delivery), subject to limitations noted on page 58.	

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IMPORTANT NOTICE TO PARTICIPANTS

September 2021

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

Briefly, this SMM reflects recent Trustee action to:

- Clarify exclusions for Accident and Sickness Weekly Benefits.
- Remove the requirement that over-the-counter medications are only eligible for reimbursement under the Health Reimbursement Account with a prescription.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

Effective January 1, 2021, the SPD is amended to provide that credits will not be paid for periods your Employer contributes to the Plan for your time on leave for a disability, and to remove the requirement that over-the-counter medications are only eligible for reimbursement under the Health Reimbursement Account with a prescription. The following changes are made to the SPD:

1. The **RULE IV. MAINTENANCE OF ELIGIBILITY OF EMPLOYEES RECEIVING DISABILITY BENEFIST (CLASS C ONLY)** section beginning on page 16 of the SPD is amended to read as follows:

> If you are eligible for coverage under the Plan and you either:
>
> **1.** receive Accident and Sickness Weekly Benefits from this Plan; or
>
> **2.** provide evidence of entitlement to benefits under any Worker's Compensation or Occupational Disease Law;
>
> you will be credited with 30 hours each week you are entitled to or are receiving such benefits, up to 780 hours per disability. This credit will begin with the first day of your disability. However, no credit will be provided for periods in which your Employer contributes to the Plan for your time on leave.

2. The **Limitations** section under the **ACCIDENT AND SICKNESS WEEKLY BENEFITS** section beginning on page 58 of the SPD is amended to add a new subsection **3.** to read as follows:

> **Accident and Sickness Weekly Benefits are <u>not</u> payable for any disability:**
>
> **1. during which you are not under the professional care and regular attendance of a Physician, Chiropractor, or D.D.S.;**
>
> **2. for any disability for which you are eligible to collect Worker's Compensation benefits or unemployment compensation; or**
>
> **3. During periods in which your Employer continues paying your wages or salary.**

3. The ***Qualifying Medical Expenses*** section under the **HEALTH REIMBURSEMENT ACCOUNT (HRA) PROGRAM** section beginning on page 64 of the SPD is amended to replace subsection 23. with the following:

> 23. Drugs, prescription and over-the-counter medications for treatment of medical conditions;

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April 12, 2021

To: All eligible members and dependents.

Last spring, the federal agencies provided relief for a number of Plan-related deadlines due to the COVID-19 national emergency. Beginning on March 1, 2020, if you were eligible to file a claim for benefits or appeal a denied claim, the Plan's deadline for you to take the action was extended for a year. You should refer to your SPD for more detail on the deadlines applicable to filing claims and appeals.

The one-year extension lasts for one year from the date you became eligible to take one of the above actions or, if earlier, the end of the COVID-19 national emergency plus 60 days. For example:

> You received a claim denial from the Plan on February 3, 2020. Under the Plan's rules, you had 60 days to file an appeal. On March 1, 2020, that 60 day period was tolled – or stopped – for a year. On March 1, 2021, your 60 day period began running again. On March 1, 2020, you had 33 days left to file your appeal. Accordingly, you must file your appeal no later than April 3, 2021.
>
> If you instead received a claim denial from the Plan on July 15, 2020, the 60 day period to file an appeal was immediately tolled. This means that on July 15, 2021, you will have 60 days to file your appeal. However, let's assume that the President declares the COVID-19 national emergency over on July 1, 2021. That would mean that on August 30, 2021, you will have 60 days to file your appeal.

IMPORTANT: If you were eligible to take one of the above actions in March 2020, your deadlines are running again and **you now have a limited number of days to take action**. If your deadline has already expired or is due to expire, you have **10 days** from the date of this letter to take action.

We will post additional information on when the COVID-19 national emergency ends or if there are any additional updates to these rules on the Plan's website. **You should regularly check the Plan's website for updated information.** If you have any questions regarding these extensions and how they apply to your situation, please contact the Plan Office.

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IMPORTANT NOTICE TO PARTICIPANTS

April 2021

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

This SMM reflects recent Trustee action to:

1. Provide that the Dental Benefit for Medicare Retiree Classes S and T will include oral surgery through Delta Dental. Oral surgery is already a covered benefit for the Active and Pre-Medicare Retiree Classes under the medical benefit.
2. Provide for 100% coverage of COVID-19 related preventive services, such as vaccines, by in-network providers and, during the COVID-19 public health emergency, out-of-network providers. This coverage is available to all participants and their dependents except for Medicare-eligible retirees covered under the Group Medicare Advantage plan. For information about coverage for COVID-19 related preventive services under the Group Medicare Advantage plan, you should contact United HealthCare.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

Effective January 1, 2020, the Plan will cover oral surgery for Medicare Retiree Classes S and T through the Dental Care Benefit. These benefits will be subject to the Dental Benefit Maximum of $2,400 every two calendar years, the $50 Dental Care deductible and the Plan's 90% Coinsurance level, for both in and out of network.

Effective December 14, 2020, the Plan will cover qualifying COVID-19 related preventive services, including vaccines and their administration, at 100% with no cost sharing. These services are available at in-network providers or, until the end of the COVID-19 public health emergency, out-of-network providers.

The COVID-19 public health emergency (also referred to as the COVID-19 National Emergency in the previous SMM you received, dated April 2020) is declared by the federal government for 90-day periods. The current COVID-19 public health emergency is effective through April 20, 2021, unless terminated early or extended for an additional 90-day period.

Summary Plan Description Updates

To reflect these changes, your SPD is revised as follows:

1. The Dental Care Benefits **Schedule of Benefits** found on page ix of your SPD (as modified by the November 2019 SMM), is replaced with the following:

DENTAL CARE BENEFITS	**Delta Dental**		**CarePlus Dental[1]**
	PPO	**Premier and Out-of-Network**	
Deductible Amount per Eligible Person	$50 every two Calendar Years	$50 every two Calendar Years	$0
Plan's Coinsurance			
Diagnostic and Preventive Services	100%[2]	100%[3]	100%[3]
Basic and Major Services	90%	90%	80%[4]
Benefit Maximum per Eligible Person	$2,400 every two Calendar Years[4]	$2,400 every two Calendar Years[5]	$2,000 each Calendar Year[5]

[1] There is no coverage for out-of-network services under the CarePlus Dental benefit.

[2] Deductible and Benefit Maximum do not apply.

[3] No deductible applies.

[4] Benefit Maximum does not apply to diagnostic and preventive services. For Eligible Persons under age 19, basic and major dental services are subject to the deductible and coinsurance but are not subject to the Benefit Maximum.

[5] Cleanings and exams are not subject to the Benefit Maximum.

DENTAL CARE BENEFITS	Delta Dental		CarePlus Dental[1]
	PPO	Premier and Out-of-Network	
Routine Orthodontic Services[6]			
Deductible Amount	$0	$0	$0
Plan's Coinsurance	100%[7]	100%	50%
Orthodontia Lifetime Maximum per Eligible Person	$2,000	$2,000	$3,000
Oral Surgery Benefit[8]			
Plan's Coinsurance	90%	90%	
Benefit Maximum	Subject to the above Benefit Maximum per Eligible Person	Subject to the above Benefit Maximum per Eligible Person	Not covered

2. The COVID-19 benefits in the Classes C, E, G, O, P,R and non-Medicare-eligible retirees and dependents of Classes S and U **Schedule of Benefits** on page x of your SPD (as modified by the April 2020 SMM) have been revised as follows:

Temporary COVID-19 Benefits	
Qualifying COVID-19 Testing	100%
Office visits (including telehealth), urgent care visits and emergency room visits that result in administration or ordering of a COVID-19 test	100%
COVID-19 related preventive care services provided by an out-of-network provider	100%

3. The COVID-19 benefits described in subsection 10 of the ***Other Covered Charges*** portion of the **COVERED CHARGES** section of the **COMPREHENSIVE MAJOR MEDICAL BENEFITS,** beginning on page 32 of your SPD (as modified by the April 2020 SMM) is revised to read as follows:

10. Effective March 18, 2020 until the end of the COVID-19 public health emergency COVID-19 virus testing, if for in-vitro diagnostic testing that is authorized by the FDA or otherwise required to be covered

[6] Orthodontics is not covered for Eligible Persons age 19 and older under the CarePlus Dental benefit.

[7] For Eligible Persons under age 19, Medically Necessary orthodontic services that are pre-approved by Delta Dental are covered at 90% coinsurance with no deductible or lifetime maximum.

[8] Medicare Retiree Classes S and T only under Delta Dental. Oral surgery for Active and pre-Medicare Retiree Classes covered under Plan's Major Medical Benefit.

under Federal law, and the related costs incurred during an office visit (including a telehealth visit), urgent care visit, or emergency room visit that results in a COVID-19 test. Coverage applies without regard to whether the test is provided in-network or out-of-network and no prior authorization or medical management requirements will apply to the qualifying COVID-19 testing. Coverage will be provided consistent with the Families First Coronavirus Response Act or other applicable Federal law, and related guidance.

4. New language is added to the ***When Obtained at an Out-of-Network Provider*** portion of the **PREVENTIVE CARE** section of the **COMPREHENSIVE MAJOR MEDICAL BENEFITS**, on page 37 of your SPD to read as follows:

When Obtained at an Out-of-Network Provider

The Plan covers preventive services including routine physical examinations, well child care, routine colonoscopy and electrocardiograms (EKG) obtained at an out-of-network provider as stated in the Schedule of Benefits. The Plan also covers the following routine immunizations:

1. For adults: tetanus, Hepatitis B, influenza, pneumonia, and shingles.

2. For Dependent children: immunizations required to attend public schools and influenza shots.

Effective December 14, 2020, until the end of the COVID-19 public health emergency, the Plan will also cover qualifying COVID-19 related preventive services with an "A" or "B" rating from the United States Preventive Services Task Force or recommended by the Advisory Committee on Immunization Practices and adopted by the Centers for Disease Control and Prevention and corresponding administration. If the purpose of an office visit is to obtain the COVID-19 related preventive service, the office visit will be covered without cost sharing. The Plan shall reimburse Out-of-Network Providers in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

5. Subsection 12 of the **Covered Expenses** portion of the **PREFERRED PROVIDER PHARMACY PROGRAM (PPRx)** section on page 51 of your SPD is revised to read as follows:

12. Preventive care drugs and immunizations recommended by the U.S. Preventive Services Task Force, Health Resource and Services Administration, or American Academy of Pediatrics, or Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, as required under the Affordable Care Act, including:

a. Over-the-counter (OTC) aspirin;

b. OTC folic acid;

c. Smoking cessation products, including OTC nicotine replacement therapy (gum, lozenge, patch, inhaler, and nasal spray) and federal legend drugs (sustained-release bupropion and varenicline), up to two 90-day supplies per 365-day period;

d. Federal legend fluoride for Dependent children six months to sixteen years of age whose primary water source is deficient in fluoride; and

e. Effective December 14, 2020, vaccines for COVID-19 that have in effect a recommendation from the ACIP that the CDC has adopted, and vaccine administration. Until the end of the COVID-19 public health emergency, such vaccines are also covered through non-PPRx providers. The Plan shall reimburse non-PPRx providers in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

* * *

Please keep this Notice with your SPD booklet for future reference.

If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

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IMPORTANT NOTICE TO PARTICIPANTS

April 2020

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

Please be advised that, although this notice must be mailed to all Fund Participants, the changes in this notice apply only to those on an Active Plan or those on a Retiree Plan who are <u>not</u> yet on Medicare. Medicare-eligible Participants on a Retiree Plan will receive information directly from UnitedHealthcare as it relates to COVID-19.

Briefly, this SMM reflects recent Trustee action to:

- Increase accident and sickness weekly benefit payments to $450 a week for any injury or sickness starting on or after March 19, 2020;
- Waive the eight-day waiting period for weekly accident and sickness benefits until the U.S. Department of Health and Human Services ("HHS") declares that the COVID-19 health emergency has ended;
- Add coverage for COVID-19 testing and diagnostic visits consistent with the Families First Coronavirus Response Act, effective March 18, 2020; and
- Add coverage for COVID-19 treatment, effective April 1 – May 31, 2020.

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

1. Effective for any accident or sickness starting on or after March 19, 2020, the Plan will increase the Accident and Sickness weekly benefit rate from $350 to $450. The benefit table on page xi of the SPD is amended to reflect this increase.

2. Effective for any accident or sickness starting on or after March 18, 2020, the Plan will waive the eight-day waiting period for accident and sickness weekly benefits until the U.S. Department of Health and Human Services declares that the COVID-19 health emergency has ended. The benefit table on page xi is amended accordingly.

The benefit table on page xi of the SPD is amended to read as follows:

Classes C and O For Active Employees Only	
DEATH BENEFITS	
Amount of Death Benefit	$20,000
Principal Sum for Accidental Death and Dismemberment	$20,000
ACCIDENT AND SICKNESS WEEKLY BENEFITS	
Weekly benefit rate	$450
Maximum number of weeks payable per disability	26
Accident and Sickness Weekly Benefits are limited to 10 days per Eligible Employee per Calendar Year for treatment of nervous and mental disorders while Hospital-confined and 30 days per each Eligible Employee's Lifetime for treatment of alcoholism and substance abuse while Hospital-confined. Benefits begin on the first day of a disability caused by an Injury and on the eighth day of a disability caused by a Sickness. Effective March 18, 2020 until the U.S. Department of Health and Human Services declares the COVID-19 health emergency has ended, there will be no waiting period for a disability caused by a Sickness. An $800 per week pregnancy and post-delivery Accident and Sickness Weekly Benefit is available for mothers who are disabled while pregnant and/or following delivery of a child for a maximum of 26 weeks. The pregnancy and post-delivery Accident and Sickness Weekly Benefit is available during pregnancy for a pregnancy-related condition resulting in disability. Following childbirth, up to six weeks of post-	

delivery benefits are payable under the pregnancy and post-delivery Accident and Sickness Weekly Benefit (up to eight weeks for Cesarean delivery), subject to limitations noted on page 58.	

3. Effective March 18, 2020 and ending when the HHS declares the end of the COVID-19 National Emergency, the Plan will provide 100% coverage of qualifying COVID-19 testing and 100% coverage of related office visits (including telehealth visits), urgent care visits, and emergency room visits that result in a COVID-19 test, consistent with the requirements of the Families First Coronavirus Response Act. New language is added to the Schedule of Benefits to reflect this change:

For Active and Retiree Classes C, E, G, O, P, R and non-Medicare-eligible retirees and dependents of Classes S and U	
COVID-19 Testing (effective from March 18, 2020 until the end of the COVID-19 National Emergency)	
Qualifying COVID-19 Testing	100%
Office visits (including telehealth), urgent care visits and emergency room visits	100%

4. Effective April 1, 2020 through May 31, 2020, the Plan will provide 100% coverage of negotiated charges for treatment of COVID-19 from an in-network provider and 100% of Reasonable Expenses for treatment of COVID-19 from an out-of-network provider. New language is added to the Schedule of Benefits to reflect this change:

For Active and Retiree Classes C, E, G, O, P, R and non-Medicare-eligible retirees and dependents of Classes S and U	
COVID-19 Treatment (effective April 1, 2020 – May 31, 2020)	
COVID-19 Treatment	100%

Additionally, a new subsection "10." is added to the ***Other Covered Charges*** section beginning on page 32 of the SPD in the **Covered Expenses** section under **Comprehensive Major Medical Benefits** to read as follows:

10. COVID-19 virus testing, if for in-vitro diagnostic testing that is authorized by the FDA or otherwise required to be covered under Federal law, and the related costs incurred during an office visit (including a telehealth visit), urgent care visit, or emergency room visit that results in a COVID-19 test. Coverage applies without regard to whether the test is provided in-network or out-of-network and no prior authorization or medical management requirements will apply to the qualifying COVID-19 testing. Coverage will be provided consistent with the Families First Coronavirus Response Act or other applicable Federal law, and related guidance.

IMPORTANT NOTICE TO PARTICIPANTS

March 2020

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD.

Briefly, this SMM reflects recent Trustee action to:

- Increase credit hours for employees receiving short-term disability benefits to 26 weeks effective for disabilities occurring on and after January 1, 2020;
- Add coverage for virtual office visits and expand LiveHealth Online coverage for behavioral health benefits; and
- Require use of the Smart-90 pharmacy program.

This SMM also describes the changes resulting from the Fund's partnership with Express-Scripts' program, SaveOnSP and updates the benefits provided under the Employee Assistance Program ("EAP") resulting from the change in EAP providers from ComPsych to TEAM Corporation ("TEAM"). Finally, a new Trustee listing is included.

SaveOnSP

To help combat the high cost of specialty medications, the Trustees have partnered with SaveOnSP. As described in other materials you have received, the SaveOnSP program can help you save money on certain specialty medications. If you are currently taking certain specialty medications, SaveOnSP may have already contacted you about participating in the program. By participating in this program, select specialty medications will be free of charge ($0). Your prescriptions will still be filled through Accredo, your existing specialty mail pharmacy.

If you are currently taking or will be taking a medication on the enclosed list *(2020 SaveOnSP Specialty Drug List),* you are eligible to participate in the SaveOnSP program. The Trustees encourage you to participate if you are eligible. If SaveOnSP has not already contacted you, you should call SaveOnSP at 1-800-683-1074 **prior to April 1, 2020** to avoid delays in obtaining your prescription(s).

If you are eligible to participate in the SaveOnSP Program but choose <u>not</u> to participate, the copay for your drug <u>will</u> increase to the amount shown on the enclosed list. Keep in mind that the copay will <u>not</u> count towards your deductible or out-of-pocket maximums.

* * *

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES

Summary of Material Modifications

1. Effective July 1, 2019, the Plan will cover virtual office visits subject to the same in-network and out-of-network terms as in-person office visits. To incorporate this change, the first sentence of item 3 of the *Physicians' Services* section on page 30 under COVERED CHARGES is amended to read:

> Medical services rendered during in-Hospital, Hospital outpatient, office, home, or virtual office visits.

Additionally, the *Online/Internet-Based Physician Visits* section on page 40 under ALTERNATIVE WAYS OF OBTAINING CARE is amended to read:

> ***Online/Internet-Based Physician Visits***
>
> You may take advantage of the Preferred Provider Online Physician Visit Program as described on page 55.

2. Effective January 1, 2020, for disabilities beginning on or after that date, the RULE IV. MAINTENANCE OF ELIGIBILITY OF EMPLOYEES RECEIVING DISABILITY BENEFITS (CLASS C ONLY) section on page 16 of the SPD is amended to credit employees up to 780 hours per disability.

3. Effective April 1, 2020, the Plan is implementing the following changes for the SaveOnSP Program:

Schedule Changes

The Preferred Provider Pharmacy Program Schedule of Benefits found on page x of your SPD is replaced with the following:

Classes C, E, G, O, P, R and non-Medicare-eligible retirees and dependents of Classes S and U For Active and Retiree Classes	
PREFERRED PROVIDER PHARMACY PROGRAM	
Retail	
Eligible Person's copayment per covered prescription for up to a 30-day supply:	
Generic	$8.00
Brand name (including multi-source brand name contraceptives)	The greater of $15.00 or 25% of the cost, to a maximum of $35.00 per prescription
ACA Preventive Care drugs, with Physician’s written prescription	$0.00

Smart-90 Retail Network	
Eligible Person's copayment per covered prescription for up to 90-day supply	
Generic maintenance drugs	$16.00
Brand name maintenance drugs	The greater of $30.00 or 25% of the cost, to a maximum of $70.00 per prescription
Mail-Service	
Eligible Person's copayment per covered prescription for up to 90-day supply	
Generic	$16.00
Brand name (including multi-source brand name contraceptives)	The greater of $30.00 or 25% of the cost, to a maximum of $70.00 per prescription
ACA Preventive Care drugs, with Physician's written prescription	$0.00
Specialty Medications (through Specialty Pharmacy)	
Eligible Person's copayment per prescription for up to a 30-day supply	
Non-Select Specialty Medications	25% of the cost, to a maximum of $50.00 per prescription
Select Specialty Medications[1]	Amount listed in the SaveOnSP Specialty Drug List[2]
Out-of-Pocket PPRx Maximum per Calendar Year	
Per Eligible Person	$5,350
Per family	$9,200

[1] The copayments for Select Specialty Medications do not apply toward satisfying your deductible or the out-of-pocket PPRx maximum.
[2] The SaveOnSP Specialty Drug List is available at www.saveonsp.com/carpenters or by contacting the Fund Office.

The **DEDUCTIBLE** section on page 26 of your SPD is replaced with the following:

DEDUCTIBLE

The deductible is the amount of covered charges you must pay before benefit payments will begin. The deductible is stated in the Schedule of

Benefits. The deductible amount will be waived for the alternative ways of obtaining care on pages 37 through 40 and preventive care on pages 36 and 37. The deductible applies only once in any Calendar Year. So that you will not have to satisfy a deductible late in one Calendar Year and soon again the following year, any expenses incurred and applied against the deductible in the last three months of a Calendar Year also may be applied toward satisfying the deductible in the next Calendar Year.

Normally, the deductible is applied separately to each Eligible Person in a family. But, if two or more eligible members of a family are injured in the same accident, only one deductible will be charged against all resulting covered charges, regardless of the number of family members injured. A combined deductible also will apply to related covered charges for such common accident incurred in subsequent Calendar Years when new deductible amounts otherwise would apply.

Copayments for Select Specialty Medications do not apply toward the deductible.

The **OUT-OF-POCKET** section on page 26 of your SPD is replaced with the following:

OUT-OF-POCKET

Reasonable Expenses you pay for covered charges (including amounts applied to the deductible amount; and the separate emergency room visit copayment) accumulate to the out-of-pocket maximum. When your out-of-pocket expenses reach the maximum stated in the Schedule of Benefits in any one Calendar Year, the Plan will pay 100% of the balance of covered Reasonable Expenses that exceed the out-of-pocket maximum for such Eligible Person(s) for the remainder of that Calendar Year. The chiropractic visit maximums will continue to apply once you have satisfied the out-of-pocket maximum.

The following charges are not included in the out-of-pocket maximum:

- Copayment reduction of 5% up to $500 for each non-emergency Hospital confinement, including inpatient admissions, that is not precertified as required;
- Copayment for out-of-network preventive care in excess of maximum;
- Amounts in excess of maximum for out-of-network chiropractic visits;
- Copayment for Select Specialty Medications (for the out-of-pocket PPRx maximum stated in the Preferred Provider Pharmacy Program Schedule of Benefits);
- Premiums;
- Balanced-billed charges; and

- Health care this Plan does not cover.

The **PREFERRED PROVIDER PHARMACY PROGRAM (PPRx)** section of your SPD is revised to describe the SaveOnSP Program and the specialty medications for which your costs will not apply to the out-of-pocket PPRx maximum. Specifically, a new section is added on page 50 above the **General Rules** section, to read:

> **SaveOnSP Program for Select Specialty Medications**
>
> The Plan uses a specialty pharmacy copay assistance program administered by SaveOnSP (the "SaveOnSP Program"). Under the SaveOnSP Program, your copayments for Select Specialty Medications are not applied toward satisfying your deductible or your out-of-pocket PPRx maximum. Additionally, the copayments that apply for the Select Specialty Medications vary from other specialty medications covered under the Plan. The SaveOnSP Specialty Drug List (available at www.saveonsp.com/carpenters or by calling the Fund Office) lists the Select Specialty Medications subject to the SaveOnSP Program and their copayments. The specialty medications and copayment amounts listed on the SaveOnSP Specialty Drug List may be changed by SaveOnSP from time to time. You should visit www.saveonsp.com/carpenters to find the most up-to-date information on specialty medications subject to the Program and copayment amounts.

The **GENERAL DEFINITIONS** section of your SPD is revised to add a new definition of "Select Specialty Medication" on page 95:

> **Select Specialty Medication** means a prescription drug which is designated as a non-essential health benefit under the Affordable Care Act by SaveOnSP and is named in the SaveOnSP Specialty Drug List that is available at www.saveonsp.com/carpenters and is incorporated by reference.

4. Effective April 1, 2020, 90 day supplies of maintenance drugs are covered only through mail order or the Smart-90 Retail Network. To reflect this change, the **Quantity Limits** section under the PREFERRED PROVIDER PHARMACY PROGRAM (PPRx) on page 49 is amended to read:

> **Quantity Limits**
>
> For each prescription purchased at a retail PPRx, you will pay the copayment for generic drugs or for brand name drugs per prescription for up to a 30-day supply as stated in the Schedule of Benefits.
>
> Maintenance prescriptions are available for purchase up to a 90-day supply through the Express Scripts Mail-Service Preferred Provider Pharmacy or the Express Scripts Smart-90 Retail Network, currently Walgreens. For each maintenance prescription filled through Express Scripts, you will pay the

copayment for generic drugs or for brand name drugs per prescription as stated in the Schedule of Benefits. Call Express Scripts at: 1-855-778-1444, or visit their website at: express-scripts.com/3-month. Express Scripts will contact your Physician to get your new prescription. You should have a one-month supply on hand when you place your order.

5. Effective April 1, 2020, the Plan is implementing the following changes for the EAP:

The **PREFERRED PROVIDER EMPLOYEE ASSISTANCE PROGRAM (EAP)** section beginning on page 54 of your SPD is replaced with the following:

PREFERRED PROVIDER EMPLOYEE ASSISTANCE PROGRAM (EAP)

Because we care about you and recognize that personal issues can affect your job performance and cause you stress, the Plan provides an EAP through TEAM . The EAP provides personal and work-life support, resources, and information to you and your Dependents. This service is provided at no cost to you and your Dependents. You or your Dependents can access the EAP by calling the TEAM toll-free number at: (800) 634-7710.

Your EAP provides help with the following:

- **Confidential Counseling** provides assessment and short-term counseling service, with ongoing case follow-up to help address issues such as stress, anxiety, and depression; marital, relationship, and family conflict; grief and loss; substance abuse; or job pressures that you or your Dependents may have.

  When you call the EAP, a professional counselor will get some general information about you and talk with you about your needs. This counselor will assess your situation and recommend next steps. You and your Dependents can each receive up to six free counseling sessions per episode of care, per year. However, if it is determined that a matter would be best met through alternative services or providers, you will be referred to a specialist for longer-term treatment that may be covered under other Plan provisions.

- **Work-Life Support Services**

  Childcare TEAM work-life consultants provide assistance with childcare needs. You can receive consultation from a trained specialist and receive assistance with finding local resources for childcare, summer care and camps. You can also access resources for child and elder care electronically.

Eldercare offers qualified geriatric care specialists and provides education and resources for caretakers, assists in locating in-home health care options and helps plan for housing transitions.

- **Legal Consultation** provides an attorney “on call” whenever you have questions about legal matters. You can speak with on-staff legal advisors about legal concerns and they can answer simple legal questions. If you require representation, you can be referred to an attorney for one free consultation for each separate legal matter. After the initial consultation, you may continue receiving legal services and a discount in the provider's customary legal fees will apply.

- **Financial Counseling** provides referrals for financial services. You can receive one free consultation with a financial professional. After the initial consultation, you can continue to receive financial services at a discounted rate from the provider's standard billing rate.

Online Resource Library provides online access to webinars, timely expert articles and information related to parenting, aging, balancing, thriving, working and living. . You can also search for qualified child and elder care, attorneys, and financial planners on the website.

The definition of *Preferred Provider Employee Assistance Program (EAP)* in the **General Definitions** section on page 94 of your SPD is replaced with the following:

“Preferred Provider Employee Assistance Program (EAP)" means the EAP which is party to a contract with Trustees, currently TEAM Corporation.

5. Effective April 1, 2020, the PREFERRED PROVIDE ONLINE PHYSICIAN VISIT PROGRAM on page 55 is amended to add behavioral health visits:

PREFERRED PROVIDER ONLINE PHYSICIAN VISIT PROGRAM

You and your Dependent can consult with a Physician through the Preferred Provider Online Physician Visit Program, LiveHealth Online, in lieu of an in-person Physician visit. You can use LiveHealth Online for common health conditions such as:

- flu
- colds
- sinus infections
- stress
- family health questions

However, for emergencies, call 911.

LiveHealth Online providers can prescribe medication, if necessary, *except* for controlled substances and lifestyle drugs.

If you sign up for **Future Moms**, you will also receive a lactation video and postpartum support.

Medical LiveHealth Online visits are generally available 24 hours a day without an appointment on your smartphone, tablet or computer. LiveHealth Online Psychology appointments are available 7 days a week, 7 a.m. to 11 p.m for adults and children ages 10 and older and are subject to appointment availability. Visit www.livehealthonline.com or download the free app to access this benefit.

Excluded Services

Excluded services include, but are not limited to, communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to Physicians outside of LiveHealth Online covered providers;
- Benefit precertification; and
- Physician to Physician consultation.

6. The **BOARD OF TRUSTEES** section on page ii of the SPD is amended to replace Pat Nilsen with Michael Adamavich as a Union Trustee, effective September 1, 2019. Additionally, a new Trustee Listing is enclosed that replaces the one found on page 119 of your SPD.

* * *

This notice also updates the information in your Summary of Benefits and Coverage ("SBC"). Specifically, in the "Important Questions" chart, the "Answer" to "What is not included in the out-of-pocket limit?" now includes "certain specialty medications." In the "Common Medical Event" chart, the "Limitations, Exceptions, & Other Important Information" section for the "If you need drugs to treat your illness or condition" row now includes the following statement: "The cost of certain specialty medications is not applied toward the out-of-pocket limit for prescription drugs."

THE NAMES AND ADDRESSES OF TRUSTEES

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North Central States Regional Council of Carpenters
2020 SaveonSP Specialty Drug List

Below are the associated copays for the medications in the SaveonSP program. Once enrolled, your responsibility will be $0.
Please call 1-800-683-1074 to enroll.

Drug Name	Monthly Copay
Abraxane	$830
Actemra	$1,250
Adcetris	$1,666
Advate	$1,000
Afinitor	$1,250
Alecensa	$2,080
AlphaNine	$5,000
Alprolix	$1,000
Austedo	$1,000
Avastin	$2,080
Avonex	$600
Benefix	$1,000
Benlysta	$1,250
Betaseron	$1,200
Bosulif	$2,080
Cabometyx	$2,080
Cerdelga	$1,250
Cimzia	$1,250
Cinryze	$1,666
Copaxone	$1,000
Cosentyx	$1,666
Cotellic	$2,080
Darzalex	$1,666
Daurismo	$2,080
Doptelet	$600
Dupixent	$1,000
Elaprase	$1,250
Empliciti	$2,080
Enbrel	$1,250
Entyvio	$1,666
Epclusa	$6,350
Erbitux	$2,080
Erivedge	$2,080
Erleada	$1,250
Esbriet	$2,080
Evenity	$600
Eylea	$1,250
Fasenra	$1,250
Firazyr	$1,666
Forteo	$750

Drug Name	Monthly Copay
Gazyva	$2,080
Gilenya	$1,666
Gilotrif	$2,080
Glatiramer	$1,000
Glatopa	$1,000
Haegarda	$1,000
Harvoni	$7,500
Herceptin	$2,080
Humira	$1,666
Hemlibra	$1,250
Ibrance	$2,080
Ilaris	$2,666
Ilumya	$1,330
Increlex	$1,000
Inflectra	$1,666
Inlyta	$2,080
Iressa	$2,166
Jakafi	$2,080
Jivi	$1,000
Kadcyla	$2,080
Kalbitor	$2,000
Kalydeco	$3,333
Kanjinti	$1,666
Kevzara	$1,250
Ledipasvir/Sofosbuvir	$7,500
Lenvima	$3,333
Letairis	$750
Lonsurf	$2,000
Lorbrena	$2,080
Lucentis	$1,666
Lumizyme	$1,250
Lupaneta Pack	$750
Lynparza	$2,166
Mayzent	$1,330
Mekinist	$1,250
Nerlynx	$2,000
Neulasta	$830
Nexavar	$2,080
Ninlaro	$2,080

Drug Name	Monthly Copay
Nivestym	$830
Northera	$1,330
Nplate	$830
Nucala	$1,250
Nuplazid	$600
Ocaliva	$1,250
Ocrevus	$1,000
Odomzo	$1,250
Olumiant	$1,000
Opdivo	$2,080
Opsumit	$1,666
Orencia	$1,250
Orenitram	$1,666
Orkambi	$3,333
Otezla	$1,000
Palynziq	$1,666
Perjeta	$2,080
Piqray	$1,250
Plegridy	$600
Polivy	$2,080
Promacta	$1,250
Pulmozyme	$830
Ravicti	$830
Rebif	$2,000
Remicade	$2,000
Remodulin	$600
Renflexis	$1,666
Revatio	$1,000
Revlimid	$830
Rituxan	$830
Rixubis	$1,000
Rydapt	$1,250
Sabril	$1,330
Serostim	$1,666
Siliq	$1,666
Simponi	$1,666
Sofosbuvir/Velpatasvir	$6,350
Somatuline Depot	$1,666
Spinraza	$2,000

Drug Name	Monthly Copay
Sprycel	$1,250
Stelara	$1,666
Stivarga	$1,330
Sutent	$2,080
Symdeko	$3,333
Tafinlar	$1,250
Tagrisso	$2,166
Takhzyro	$3,333
Taltz	$1,330
Talzenna	$2,080
Tarceva	$2,080
Tasigna	$1,250
Tecentriq	$2,080
Tecfidera	$600
Tegsedi	$2,000
Tobi Podhaler	$1,000
Tracleer	$1,000
Tremfya	$1,666
Treprostinil	$600
Tykerb	$1,250
Udenyca	$1,250
Uptravi	$830
Valchlor	$1,666
Ventavis	$830
Verzenio	$2,080
Vitrakvi	$2,000
Vizimpro	$2,080
Vosevi	$6,350
Votrient	$1,250
Vyndaqel	$5,000
Xalkori	$2,080
Xeljanz	$1,250
Xgeva	$830
Xolair	$1,000
Xtandi	$2,080
Yervoy	$2,080
Zarxio	$830
Zelboraf	$2,080
Zydelig	$2,080

Copays may vary based on drug manufacturer allowed amounts
Drug list is subject to change
The inclusion of eligible drugs within the Program is subject to applicable laws or regulations

Updated 09/18/2019
Effective 01/01/2020

IMPORTANT NOTICE TO PARTICIPANTS

December 2019

To All Participants:

The Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Fund") regularly review the Summary Plan Description/Plan Document ("SPD") and make changes when necessary. Please take time to read this notice, which is called a summary of material modifications ("SMM"), carefully and thoroughly because it contains important information regarding changes to the SPD. Briefly, this SMM describes the following changes:

1. Effective March 1, 2018, classroom hours in any Training Center in the North Central States Regional Council of Carpenters' jurisdiction will count toward credit of hours for eligibility purposes.

2. Effective September 1, 2019, you must seek prior authorization for genetic treatments. If you do not seek prior authorization and the genetic treatment is determined to be not Medically Necessary, coverage will be denied. Additionally, the Plan will cover most genetic treatments as medical benefits but the gene therapy Zolgensma will be covered under the prescription drug benefit.

3. Effective November 1, 2019, you may submit reimbursements for Plan covered medical expenses directly to the HRA without first seeking coverage under the Plan. Additionally, HRA reimbursements will be made on a monthly basis.

4. Effective December 5, 2019, the precertification requirements are clarified to confirm that only non-emergency in-patient admissions must be precertified or are subject a reduction in copayment.

5. Effective January 1, 2020:

(a) The Fund's vision benefit will be provided by Anthem and will include a new safety eyewear benefit for active employees. The vision benefits have also been changed. Please review the rest of the SMM for specific details.

(b) The Delta Dental Benefit Maximum is increased to $2,400 every two calendar years, the dental deductible is increased to $50 every two calendar years, and annual preventive and diagnostic services will be paid at 100% and not subject to deductible or biennial maximum. There is no change to the CarePlus Dental benefit.

(c) The Fund's Medicare retiree benefit is now being provided through the UnitedHealthCare Group Medicare Advantage and Prescription Drug Plan ("MAPDP"). Medicare-eligible retirees will receive a separate mailing with information on the new MAPDP benefit.

(d) The Fund's self-funded organ transplant benefit for Medicare-eligible retirees is eliminated.

6. Effective February 1, 2020, the Retiree Subsidy Rates will be adjusted.

7. Effective July 1, 2020, Medicare-eligible retirees must enroll in Medicare Parts A and B when they are eligible. If a Medicare-eligible retiree fails to enroll in Medicare Parts A and B, he or she will no longer be eligible for coverage under the Plan.

Because some of these changes effect the same plan provisions, the SMM describes the changes together and in the order in which they are found in the SPD for clarity. However, please refer back to the effective dates noted above for questions on any specific rule change.

Schedule Changes

The vision and dental schedules of benefits found on page ix of your SPD are replaced with the following:

Classes C, G, O, P, S, and T **For Active and Optional Retiree Classes** **VISION CARE BENEFITS**		
	In-Network Provider	Non-Network Provider
Routine Eye Exam Limited to one per calendar year	$0	Up to $42 allowance
Prescription Lenses Includes factory scratch coating and, for Eligible Persons under age 19, polycarbonate lenses and photochromic lenses when received from network providers. Limited to one set of lenses per Eligible Person every two calendar years.		
Single vision lenses	$0	Up to $40 allowance
Bifocal lenses	$0	Up to $60 allowance
Trifocal lenses	$0	Up to $80 allowance
Frames Limited to one set of frames per Eligible Person every two calendar years	Up to $130 allowance then 20% off any balance	Up to $45 allowance
Prescription Contact Lenses[1] Available once every two calendar years		
Elective conventional (non-disposable) contact lenses	Up to $130 allowance then 15% off any balance	Up to $105 allowance
Elective disposable contact lenses	Up to $130 allowance	Up to $105 allowance
Medically necessary contact lenses	$0	Up to $210 allowance

[1] Contact lenses are in lieu of your eyeglass lens benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this Schedule of Benefits.

Classes C, G, O, P, S, and T For Active and Optional Retiree Classes **VISION CARE BENEFITS**
If you receive covered eyewear from a Blue View Vision provider, you may be eligible for additional discounts on vision benefits such as lens enhancements, additional glasses, contact lens fittings, LASIK surgery.

Classes C and O For Active Employees Only **SAFETY VISION CARE BENEFITS**		
	In-Network Provider	Non-Network Provider
Eyewear Frame Limited to one set of frames per Participant every other calendar year	Up to $100 allowance then 20% off any balance	Up to $45 allowance
Lenses Includes factory scratch coating and polycarbonate lenses when received from network providers. Limited to one set of lenses per Participant every two calendar years.		
Single vision lenses	$0	Up to $40 allowance
Bifocal lenses	$0	Up to $60 allowance
Trifocal lenses	$0	Up to $80 allowance
If you receive covered eyewear from a Blue View Vision provider, you may be eligible for additional discounts on lens enhancements.		

DENTAL CARE BENEFITS	**Delta Dental**		**CarePlus Dental[2]**
	PPO	**Premier and Out-of-Network**	
Deductible Amount per Eligible Person	$50 every two Calendar Years	$50 every two Calendar Years	$0
Plan's Coinsurance			
Diagnostic and Preventive Services	100%[3]	100%[3]	100%[4]
Basic and Major Services	90%	90%	80%[4]

[2] There is no coverage for out-of-network services under the CarePlus Dental benefit.
[3] Deductible and Benefit Maximum do not apply.
[4] No deductible applies.

DENTAL CARE BENEFITS	Delta Dental		CarePlus Dental[2]
	PPO	Premier and Out-of-Network	
Benefit Maximum per Eligible Person	$2,400 every two Calendar Years[5]	$2,400 every two Calendar Years[5]	$2,000 each Calendar Year[6]
Routine Orthodontic Services[7]			
Deductible Amount	$0	$0	$0
Plan's Coinsurance	100%[8]	100%	50%
Orthodontia Lifetime Maximum per Eligible Person	$2,000	$2,000	$3,000

Additionally, the first row of the Preferred Provider Pharmacy Program schedule on page x of your SPD is replaced with the following:

Classes C, E, G, O, P, R and non-Medicare-eligible retirees and dependents of Classes S and U For Active and Retiree Classes

The Retired Employees schedule on page xii is replaced with the following:

For Retired Employees and Dependents and Surviving Spouses	
The following benefits are available for Classes P, R, S, T, U, and V:	
COMPREHENSIVE MAJOR MEDICAL BENEFITS and PREFERRED PROVIDER PHARMACY PROGRAM	
Classes P, R, S and U (non-Medicare-eligible retirees and dependents only)	Identical to Class C
Classes T, V, S and U (Medicare-eligible retirees and dependents only)	Medical and prescription drug benefits are available solely through the Group Medicare Advantage plan
VISION CARE BENEFITS	Classes P, S, and T only[1]

[5] Benefit Maximum does not apply to diagnostic and preventive services. For Eligible Persons under age 19, basic and major dental services are subject to the deductible and coinsurance, but are not subject to the Benefit Maximum.
[6] Cleanings and exams are not subject to the Benefit Maximum.
[7] Orthodontics is not covered for Eligible Persons age 19 and older under the CarePlus Dental benefit.
[8] For Eligible Persons under age 19, Medically Necessary orthodontic services that are pre-approved by Delta Dental are covered at 90% coinsurance with no deductible or lifetime maximum.
[1] **Please Note:** At the time of retirement, you have a one-time option to elect vision and dental coverage at an additional cost. This coverage is provided under Classes P, S, and T.

For Retired Employees and Dependents and Surviving Spouses **The following benefits are available for Classes P, R, S, T, U, and V:**	
DENTAL CARE BENEFITS	Classes P, S, and T only[1]
DEATH BENEFITS (Employees Only)	
Amount of Death Benefit	$4,000
Principal Sum for Accidental Death and Dismemberment	$4,000
ACCIDENT AND SICKNESS WEEKLY BENEFITS	No Coverage

The Preauthorization chart on page xviii is revised to include gene therapy:

Gene Therapy

- All gene therapy

The first paragraph of Eligibility Rule I: Initial Eligibility on page 2 of your SPD is replaced with the following:

RULE I. INITIAL ELIGIBILITY

Bargaining Unit Employees, Non-Bargaining Unit Employees, and Alumni

You and your Dependents become initially eligible on the first day of the second month following the month in which you have worked and are credited with at least 500 hours of contributions at the Prevailing Contribution Rate as shown in the following chart. Hours spent in the classroom of any Training Center in the North Central States Regional Council of Carpenters' jurisdiction are considered hours for eligibility. Hours contributed at less than the Prevailing Contribution Rate will be prorated. Such contributions must be credited within 12 consecutive months.

The Retiree Eligibility provisions within Eligibility Rule III: Self-Payment Options (pages 6-10 of your SPD) are replaced with the following:

When an Employee Retires or is Totally and Permanently Disabled

Please Note: Retiree benefits are not vested and are subject to change or discontinuation as determined by Trustees. Trustees retain the right in their sole discretion to modify or discontinue retiree eligibility rules, types and amount of benefits, terms and conditions under which benefits are payable, and self-payment rates.

You will be considered retired for Plan purposes when you receive a

retirement or disability benefit from the North Central States Regional Council of Carpenters' Pension Fund or another construction industry pension fund. At that time, you may use your accumulated eligibility (banked hours). However, when you have used your banked hours, you no longer will be eligible to continue coverage under any of the active Employee programs.

Exception: If you work and are credited with 390 or more hours during any Work Quarter, and you and/or your Spouse are Medicare-eligible, the Medicare-Eligible Person(s) will receive Class C active Employee benefits for the corresponding Coverage Quarter. If in any subsequent Work Quarter you are credited with less than 390 hours, benefits for the Medicare-Eligible Person(s) for the corresponding Coverage Quarter will revert back to the Class under which you were covered just prior to reinstatement in Class C.

You will have a one-time opportunity when you retire to elect coverage under the Retiree Program. If you elect not to continue coverage in the Retiree Program at the time of your retirement, you will not be allowed to elect such coverage at a later date unless you qualify for the one-time waiver/reinstatement provision on page 10. Retiree coverage will become effective no later than the first day of the quarter for which the active self-payment (based on hours worked prior to retirement date) exceeds the Retiree Program self-payment, provided you have completed the proper application for such coverage.

1. **Retiree Program Requirements**

   When you retire, you may continue coverage under the Plan provided you satisfy the following requirements.

   a. provide written proof of retirement from your pension fund, be receiving Social Security retirement benefits, or, for Non-Bargaining Unit or Alumni Employees, provide:

      (i) If an owner, documentation of the change of officers filed with the state or proof of sale of the company.

      (ii) If an officer, documentation of the change of officers filed with the state and a letter from the company verifying the change.

      (iii) If an office Employee who is not an owner or officer, a letter from the company verifying your retirement; and

   b. be eligible as an active Employee during the Coverage Quarter immediately preceding the effective date of coverage in the Retiree Program [however, this requirement will be waived if you: became permanently partially disabled, as determined by Trustees, on or after January 1, 2001; retired on or after January 1, 2005; were credited with 35,000 or more hours of contributions from contributing Employer(s) at the time of retirement; and are unable to perform enough Covered Work due to such disability in order to

be eligible in the Coverage Quarter immediately preceding retirement]; and

c. have contributions made on your behalf by a contributing Employer(s) in each of the five years immediately preceding retirement [however, this requirement will be waived if you have been credited with 20,000 or more hours of contributions from contributing Employer(s) at the time of your retirement]; and

d. make the self-payment no later than the 25th day of the month preceding the current Coverage Month at a rate to be determined by Trustees from time to time. Self-payments postmarked by the 15th day of the month preceding the current coverage month will be considered timely.

If you are unable to satisfy the requirement in the prior subparagraph 1.c. because the collective bargaining unit in which you are employed has not participated in the Fund for five years. Eligibility for participation may be determined by Trustees in other ways than from Fund records, such as determining your relationship to the industry prior to the bargaining unit joining the Fund. Further, solely for the purpose of satisfying subparagraph 1.c., hours of employment with the Carpenters Industrial Council prior to its merger into the Union shall be credited for purposes of satisfying the 20,000-hour requirement.

If you satisfy the above requirements, you will have the choice of the following benefits for yourself and your Dependents:

If you are not yet Medicare-eligible: Health Care Benefits only or, at your option, Health Care, Vision Care, and Dental Care Benefits.

If you are Medicare-eligible: Group Medicare Advantage plan only or, at your option, Group Medicare Advantage plan, Vision Care and Dental Care Benefits provided you also enroll in Medicare Part A and Part B. If you fail to enroll in Medicare Part A and Part B, you will not be eligible for Plan coverage.

If you are Medicare-eligible and do not enroll in the Group Medicare Advantage plan, there is no other Plan coverage available to you.

2. **Retiree Program Reinstatement**

When you or your surviving Spouse fail to make the required self-payment when due, you lose eligibility. However, you may request reinstatement of eligibility to participate in the Retiree Program. Such request for reinstatement must be made within 90 days of the date your eligibility otherwise would terminate and include an explanation satisfactory to Trustees of why it was not reasonably possible for you to make the required self-payment when due.

When your or your surviving Spouse's request for reinstatement in the Retiree Program is made within 90 days of the date your coverage otherwise would terminate and such request is approved, the required self-payment will be accepted retroactive to the first day of the first month for which a self-payment was not made.

3. **Eligibility for Retiree Program Subsidized Self-Payments**

In order to qualify for a subsidy, you must be a member of a participating Union or pay a service fee to a carpenters' local Union. Persons retiring at age 55 or later with a minimum of 10 years of service under this Plan, having at least 10,000 hours, will be eligible for a subsidy if available. *Owners must submit proof of retirement before the subsidy will be granted.* Totally and Permanently Disabled Participants will be eligible for a subsidy regardless of age to the extent they qualified prior to their disability.

Retirees age 55 or over with a minimum of 10 years of service and:	Percentage of Subsidy	
	Medicare-Eligible	Non-Medicare-Eligible
0-9,999 hours	0%	0%
10,000-14,999 hours	10%	10%
15,000-19,999 hours	15%	15%
20,000-24,999 hours	20%	20%
25,000-29,999 hours	25%	25%
30,000-34,999 hours	35%	35%
35,000 or more hours	45%	45%

The percentage of subsidy for persons who retired prior to November 1, 2000, will not increase or decrease by more than 5% from the percentage of subsidy in effect April 30, 2002, in recognition of prior Trustee action which provided a 35% subsidy for persons who retired prior to November 1, 1995, and further provided a five-year transition rule for persons who retired on or after November 1, 1995, but prior to November 1, 2000.

Subsidy rates will not increase after retirement because of your age or return to Covered Employment.

Surviving Spouses are eligible for the Retiree Program and the scheduled subsidy to the extent you satisfied the eligibility requirements. If you die either before or after retirement, your surviving Spouse retains the rights to your subsidized rate, so long as Trustees continue the practice.

Trustees will reevaluate subsidies from time to time to make sure they are in line with the Fund's best interests. Any adjustments in the percent of subsidy in the future will affect each percentage category.

If you are a non-Medicare-eligible retiree who works for wage or profit for any non-signatory Employer in the construction industry or performs Covered Work for wage or profit for any non-signatory Employer, including work in an industrial trade you learned through Covered Employment, your eligibility to make subsidized self-payments will cease as of the last day of the month in which you begin such employment. If, within 60 days of the date your eligibility for a subsidy ends, you submit proof that your non-covered employment is terminated, your eligibility for a subsidy will be reinstated on a one-time basis.

If you are a retired Employee who continues to work at such non-covered employment, you will be eligible to make nonsubsidized self-payments at a rate to be determined by Trustees from time to time. If you continuously make nonsubsidized self-payments under this provision, and you otherwise are eligible for a subsidy under these Eligibility Rules, you will once again be eligible for a subsidy when you are enrolled in Part A and Part B of Medicare.

4. **Eligibility for Retiree Program Nonsubsidized Self-Payments**

You may make **nonsubsidized** self-payments under the Retiree Program at a rate to be determined by Trustees from time to time if you:

a. Satisfy the Retiree Program requirements stated in paragraph 1, but who do not qualify for a subsidy.

b. Do not maintain membership in a participating Union or do not maintain continuous payment of a service fee to the Health Fund.

Retirees who choose not to continue coverage under the Self-Payment Option 1-Retiree Program may choose to continue coverage under Self-Payment Option 2-COBRA continuation coverage.

5. **Retiree Program Waiver/Reinstatement Provision**

Retirees will have a **one-time** option to waive Health Plan coverage. If you are eligible to continue, or you are currently continuing coverage under the Retiree Program, you may elect to waive or terminate eligibility for all Health Plan benefits if you are enrolled in another employer-sponsored group health plan. You and your Spouse, if applicable, must sign a waiver form certifying your coverage under another group health care plan and submit proof of such coverage. The

waiver will be effective as of the first day of the month following receipt of the waiver form and proof of other coverage. However, if you have accumulated eligibility under the Active Plan, the waiver will take effect when your accumulated eligibility runs out.

You can reinstate coverage in the Plan only at the time you and your Spouse, if applicable, terminate or become ineligible for the other group health coverage. To be eligible for reinstatement, you must submit an enrollment form to the Fund Office within 60 days following termination of coverage under the other group health plan along with proof that you and all your eligible Dependents were continuously covered under another employer-sponsored group health care plan after waiver of coverage under this Health Plan. Coverage will be reinstated on the first day of the month following receipt of an enrollment form, proof of other coverage, and the applicable self-payment.

Your eligibility for a subsidy, if any, is frozen when the waiver takes effect. You will be eligible for the subsidy applicable to your years of service and hours credited prior to retirement based on the rules in effect on the date of reinstatement into the Retiree Program. The self-payment amount will be based on the applicable rate at that time.

The **OUT-OF-POCKET** section on page 26 of your SPD is replaced with the following:

OUT-OF-POCKET

Reasonable Expenses you pay for covered charges (including amounts applied to the deductible amount; and the separate emergency room visit copayment) accumulate to the out-of-pocket maximum. When your out-of-pocket expenses reach the maximum stated in the Schedule of Benefits in any one Calendar Year, the Plan will pay 100% of the balance of covered Reasonable Expenses that exceed the out-of-pocket maximum for such Eligible Person(s) for the remainder of that Calendar Year. The chiropractic visit maximums will continue to apply once you have satisfied the out-of-pocket maximum.

The following charges are not included in the out-of-pocket maximum:

- Copayment reduction of 5% up to $500 for each non-emergency Hospital confinement, including inpatient admissions, that is not precertified as required;
- Copayment for out-of-network preventive care in excess of maximum;
- Amounts in excess of maximum for out-of-network chiropractic visits;
- Premiums;
- Balanced-billed charges; and

- Health care this Plan does not cover.

The **COVERED CHARGES** section of your SPD is revised to include coverage for gene therapy and to clarify the precertification requirements for surgical benefits. Specifically, covered charge number 2 under ***Hospital Services*** on page 27 is revised to read:

> 2. Drugs, medicines, gene therapies, diagnostic x-rays and laboratory tests, and other Hospital miscellaneous services and supplies not included in the room charges, if used while confined in the Hospital as a resident patient;

Footnote 1 on page 28 is replaced with the following:

> It is recommended that certain procedures specified on page xviii be preauthorized or Plan benefits will be denied if they are determined not to be Medically Necessary.

Additionally, covered charge number 4 under ***Drugs and Medicines*** on page 32 is revised to read:

> 4. Drugs and medicines, including gene therapies, administered by a Physician. Preauthorization is recommended for specialty medications given in an office setting including, but not limited to Orencia, Remicade; iron infusions; and gene therapies (see page xviii).

The **COVERED CHARGES** section of your SPD is also revised to eliminate the self-funded organ transplants for Medicare-retirees. The ***Organ Transplants*** section on page 34 is replaced with the following:

> ***Organ Transplants****.* Benefits for covered charges for cornea transplants. *All other organ and tissue transplant coverage is provided under a separate insurance policy (described in Organ & Tissue Transplant Certificate attached as Appendix B). Such policy pays benefits for certain organ and tissue transplants without regard to any benefits that may be provided by the Plan. Refer to the enclosed Certificate for benefit information, preauthorization of transplant services, and transplant network provider access. Expenses billed by the transplant provider that are not covered by the Certificate are subject to the Plan's benefits and the payment terms and conditions of the transplant provider's contracted rates.*

Additionally, the first sentence on page 35 is revised to eliminate the reference to Medicare-approved organ transplants.

The **EXCEPTIONS AND LIMITATIONS** section on page 40 of your SPD is revised to clarify that the gene therapy Zolegnsma is not covered under the Comprehensive Major Medical Benefit by adding the following:

> 6. Zolgensma.

The **VISION CARE BENEFITS** described in page 41 of the SPD is replaced with the following:

Vision Care Benefits are characterized under the Plan as an excepted benefit under HIPAA and the Affordable Care Act.

Benefit Maximums, Allowances and Frequency Limits

Vision benefits are subject to benefit maximums, allowances and frequency limits. Vision care services that go over your benefit maximums or allowances, or that are received more than the allowed frequency limits are not covered. Benefit maximums, allowances, and frequency limits are stated in the Schedule of Benefits.

Your Cost Share Requirements

The Plan pays up to the maximum allowable amount for covered services. You may be required to pay a part of the maximum allowable amount. See the Schedule of Benefits for your cost share amount for covered services.

Your cost share amount may vary depending on whether you receive vision care from a network or non-network provider. You may be required to pay higher cost sharing amounts when using non-network providers.

The Plan does not pay for vision care that is not covered. You are required to pay all charges for vision care that is not covered.

Covered Services

Services and supplies or treatment which are performed, prescribed, directed or authorized by a provider. To be a covered service the service, supply or treatment must be:

- Within the scope of the license of the provider performing the service;
- Rendered while coverage is in force;
- Within the maximum allowable amount;
- Not specifically excluded or limited;
- Specifically included as a benefit.

A covered service is incurred on the date the service, supply or treatment was provided to you. The maximum amount allowed for covered vision services is based on the fee schedule. All covered services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Plan.

Routine Vision Benefits

Routine Eye Exam. A complete eye exam with dilation as needed is covered. An eye exam does not include a contact lens fitting fee.

Eyeglass Lenses. You have a choice in your eyeglass lenses. Eyeglass lenses include factory scratch coating at no additional cost. Your dependent children under 19 may also receive polycarbonate and photochromic eyeglass lenses at no additional cost when received from a network provider.

Covered eyeglass lenses include plastic lenses up to 55 mm in single vision, bifocal, trifocal.

Frames. You have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

Contact Lenses. The Plan covers elective or non-elective contact lenses. You may receive a benefit for elective contact lenses or non-elective contact lenses, but not both.

> **Note:** Contact lenses are in lieu of your eyeglass lens benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the Schedule of Benefits.

Elective Contact Lenses. Elective contact lenses are contacts that you choose for appearance or comfort. The contact lens allowance must be completely used at the time of initial service. The Schedule of Benefits lists the contact lens allowance available.

Non-Elective Contact Lenses. Non-elective contact lenses are prescribed by your provider for diagnoses listed below:

- Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
- Keratoconus-unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
- High Ametropia-unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
- Anisometropia-when one eye requires a much different prescription than the other eye

Important Note: Non-elective contact lenses for any Eligible Person who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK are not covered.

Safety Vision Benefits – Active Employees Only

Safety Eye Exam. The Plan covers a complete eye exam with dilation as needed. An eye exam does not include a contact lens fitting fee.

Safety Eyewear Lenses. You have a benefit allowance to apply towards your choice of safety eyeglass lenses. If the eyeglass lenses you pick are more than your allowance, then you are responsible to pay for the difference.

Safety Eyewear Frames. You have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

Additional Options. Benefits are available for additional services in accordance with the Additional Savings Program. For additional information on available discounts please contact the Plan Office.

Limitations

In addition to General Exclusions on pages 78 through 83, Vision Care Benefits do not cover:

1. Services not listed in the Covered Services section.

2. Any amounts in excess of the maximum benefits.

3. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.

4. This includes non-prescription eyewear and lenses, plano lenses or lenses that have no refractive power.

5. Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. Contact lenses or eyeglasses required as a result of this surgery are also excluded.

6. Any lost or broken lenses or frames, unless you have reached a new benefit period.

7. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or

state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

8. Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.

9. Inpatient or outpatient hospital vision care.

10. Orthoptics or vision training and any associated supplemental testing.

11. Your benefit allowance under this plan will not apply to services or supplies when combined with other offers, coupons or in-store advertisements. However, if your provider chooses, they may apply offers, coupons or in-store advertisements to the remaining balance.

The **PREFERRED PROVIDER PHARMACY PROGRAM (PPRx)** section on **Covered Expenses** section is revised to add coverage for the gene therapy Zolgensma. Specifically, Covered Expense number 10 on page on page 51 of the SPD is replaced with the following:

10. Infused medications, the gene therapy Zolgensma, and other specialty medications administered by a Physician, at the Physician's option. Preauthorization is recommended for gene therapies (see page xviii).

The **PREFERRED PROVIDER OPTICAL CENTER** section on pages 53-54 of your SPD is replaced with the following:

PREFERRED PROVIDER OPTICAL CENTER

Network Providers. Anthem has a network of vision care providers for you to use. These network providers have agreed to take part in the Blue View Vision network. They have agreed to provide covered services to you for a negotiated rate. Covered services you receive from the network provider are considered In-Network care.

If you opt to receive optometric services or procedures that are NOT covered services under the Plan, a network provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with optometric services or procedures that are not covered services, the provider should provide you with a treatment plan that includes each anticipated service or procedure to be given and the estimated cost of each service or procedure.

Non-Network Providers. Non-network providers are vision care providers that did not agree to participate in the Blue View Vision network. They have

not agreed to a negotiated rate and do not have a provider contract with Anthem. Using a non-network provider will typically increase your out of pocket costs. Covered services you receive from non-network providers are considered Out-of-Network care.

Please call Anthem at 1-800-810-2583 or visit their website at www.anthem.com for help in finding a network provider.

The **HEALTH REIMBURSEMENT ACCOUNT (HRA) PROGRAM** section on **ORDERING RULES** found on page 69 of the SPD is replaced with the following:

ORDERING RULES

If your or your Dependent's expenses are covered under the HRA Program and a health flexible spending account under a Code Section 125 cafeteria plan, or under another health reimbursement arrangement, such claims must be submitted to the health flexible spending account or other health reimbursement arrangement before they are submitted to the HRA Program.

The **MEDICARE PROVISIONS** on page 74 is revised to delete the second paragraph.

The definition of **Classes of Eligible Persons** on page 87 is replaced with the following:

Classes of Eligible Persons means all the classifications of coverage under the Plan as follows:

Class C (Active): Employees (and their Dependents) of Employers obligated by a collective bargaining agreement to pay contributions to this Fund.

The term “Employees” includes Bargaining Unit Employees and, provided the Employer is party to an approved participation agreement, certain Non-Bargaining Unit or Alumni Employees.

Class O (Active Employees of Industrial Employers): An Industrial Employer’s Bargaining Unit and Non-Bargaining Unit Employees (and their Dependents) who satisfy the applicable Eligibility Rule requirements.

Class E and G (COBRA):

1. *Class E* – An Eligible Person continuing coverage for Comprehensive Major Medical Benefits through COBRA self-payments.

2. *Class G* – An Eligible Person continuing coverage for Comprehensive Major Medical Benefits, Vision Care Benefits, and Dental Care Benefits through COBRA self-payments.

Class P, R, S, T, U and V (Retired):

1. *Class P* – Retired Employees and their Dependents who are not eligible for Medicare and who are continuing Comprehensive Major Medical Benefits, Vision Care Benefits, and Dental Care Benefits through self-payments.

2. *Class R* – Retired Employees and their Dependents who are not eligible for Medicare and who are continuing Comprehensive Major Medical through self-payments.

3. *Class S* – Retired Employees and their Dependents, one of whom is eligible for Medicare and the other is not, who are continuing Comprehensive Major Medical Benefits, Vision Care Benefits, and Dental Care Benefits through self-payments.

4. *Class T* – Retired Employees and their Dependents who are both Medicare-eligible and who are continuing Comprehensive Major Medical Benefits, Vision Care Benefits, and Dental Care Benefits through self-payments.

5. *Class U* – Retired Employees and their Dependents, one of whom is eligible for Medicare and the other is not, who are continuing Comprehensive Major Medical through self-payments.

6. *Class V* – Retired Employees and their Dependents who are both Medicare-eligible and who are continuing Comprehensive Major Medical through self-payments.

Please Note: Early retirees/Spouses who become initially entitled to Medicare due to End Stage Renal Disease will remain in an early retiree Class (R or P) until the full 30-month coordination period specified in the Medicare Provisions on page 74 has elapsed (even if such person turns age 65 during that period).

Medicare-eligible retirees and/or Spouses in Classes U, S, V, and T who cover children under age 26 will have their self-payment amount based at the level required for retired Employees and Spouses who are not Medicare-eligible (Classes R and P).

The definition of *Preferred Provider Optical Center* on page 94 is replaced with the following:

"Preferred Provider Optical Center" means the optical center that is party to a contract with the Trustees, currently Anthem.

The **HOW TO APPLY FOR BENEFITS** section beginning on page 97 of your SPD is revised to clarify the rules for **PRE-SERVICE CLAIMS** and to update the contact

information in the **POST-SERVICE CLAIMS**. The **PRE-SERVICE CLAIMS** section is replaced with the following:

PRE-SERVICE CLAIMS:

It is recommended that you obtain Preauthorization for certain services and supplies as specified on page xviii or Plan benefits will be denied if determined not to be Medically Necessary. Precertification is required for any non-emergency Hospital confinement to be eligible for the maximum level of benefits. Also, you must contact the Fund Office for prior approval for all organ transplants. These claims are called, "pre-service claims," which means any claim that requires approval of the benefit in advance of obtaining medical care. Pre-service claims may be submitted initially by telephone or in writing to CMS.

There are special provisions in the Claims Procedure Regulations for "urgent care claims" (referred to under the Plan as "emergencies"), but, by definition, these provisions do not apply because the Plan does not require prior approval of emergency admissions.

The contact information included in the **POST-SERVICE CLAIMS** section is replaced with the following:

Send all insured organ transplant claims to:

OT Claims Department
P.O. Box 3028
Costa Mesa, CA 92626

Send all dental claims to the dental program in which you are enrolled:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481-0828

CarePlus Dental
3333 North Mayfair Road, Suite 311
Wauwatosa, WI 53222

Send all claims for vision to:

Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

After you receive vision care from a non-network provider, you will need to contact Anthem, either by phone or mail within 20 days of the date you received vision care to obtain claim forms for filing (or as soon as possible). Anthem will provide claim forms within 15 days after notification. The claim

form will have instructions on how to fill it out and where to submit. If you do not receive a claim form within 15 days of your claim notice, you may send an itemized bill instead. The itemized bill should include the following:

1. The date of service;
2. The patient's name, date of birth, and identification number;
3. The type and place of service;
4. Your signature and the provider's signature.

You must provide the claim form or an itemized bill to Anthem within 90 days after the date you received vision care. If it is not reasonably possible to provide your claim form/itemized bill within this time, your claim will not be invalidated or reduced but you must send it as soon as reasonably possible, and in no event later than a year from when it was due, unless you are legally incapacitated.

Claims will be paid immediately upon receipt of written proof of your claim, but generally no later than 60 days after receipt of a complete claim.

Send all claims for Death and Accidental Death and Dismemberment Benefits to:

Fund Office
North Central States Regional Council of Carpenters' Health Fund
P.O. Box 4002
Eau Claire, WI 54702

Send all other medical claims for services obtained in Wisconsin to:

Anthem Blue Cross and Blue Shield
P.O. Box 34210
Louisville, KY 40232-4210

Send all other medical claims for services obtained outside Wisconsin to your local Blue Cross and Blue Shield Plan.

Claims should be complete, including, at a minimum:

1. Fund name (North Central States Regional Council of Carpenters' Health Fund);
2. Participant's name and identification number;
3. full name (including "Jr.," if applicable) and date of birth of the Eligible Person who incurred the covered expense;
4. name and address of the service provider;
5. federal tax identification number of provider;
6. diagnosis of the condition;
7. procedure or nature of the treatment;

8. date of and place where the procedure or treatment has been provided; amount billed and the amount of the covered expense not paid through coverage other than this Plan, as appropriate; and
9. evidence that substantiates the nature, amount, and timeliness of each covered expense that is in a reasonably understandable format and is in compliance with all applicable law.

* * *

Please keep this Notice with your SPD booklet for future reference. If you have any questions, feel free to call the Fund Office.

Yours very truly,

THE BOARD OF TRUSTEES