4208 W. Partridge Way, Unit 3 • Peoria, IL 61615

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Date: May 2020

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

From: The Board of Trustees

The Trustees of the North Central Illinois Laborers' Health and Welfare Fund (the "Fund") recognize that these are trying times as the country copes with the COVID-19 (novel 2019 coronavirus) health crisis. This Summary of Material Modifications (SMM) provides details about the Plan's coverage for COVID-19 diagnostic testing and associated provider visits. It also announces the expansion of your coverage for telehealth visits and the Plan's new coverage for gene therapy. Please read this SMM in its entirety to make sure you understand your enhanced health care coverage.

No Deductible, Copays or Coinsurance for COVID-19 Diagnostic Testing and Associated Provider Visits

If you're showing symptoms of the coronavirus or believe you have been exposed to it, we encourage you to take appropriate action. The Fund will cover diagnostic testing and other testing as required by federal guidance (including nasal swabs) for the novel 2019 coronavirus and / or COVID-19 at 100% (in other words, no deductible, copay or coinsurance). In-network and out-of-network office visits (including telehealth visits, as discussed below), urgent care visits, emergency room visits and other laboratory or radiology services associated with the coronavirus and/or COVID-19 diagnostic testing are also covered by the Fund at 100%, as are items or services provided during those provider visits to the extent that they relate to the furnishing or administration of the diagnostic test or the evaluation of whether you need the test.

Coverage also includes non-traditional settings, such as drive-thru testing sites where licensed providers administer tests, and other items or services provided during those visits to the extent that they relate to the furnishing or administration of the diagnostic test or the evaluation of whether the test is needed.

Related tests furnished during the visit (such as blood tests and flu tests) will be covered without cost-sharing if the visit results in the ordering or administration of the COVID-19 test.

No preauthorization is required for the testing. However, it must be medically necessary by the treating provider and consistent with the Centers for Disease Control (CDC) and federal guidance.

The Plan will provide the above items and services March 18, 2020 through December 31, 2020, unless otherwise determined by the Board of Trustees or required under federal law.

Expanded Coverage for Telehealth Services

As you know, the Plan offers the convenience of telehealth medical and behavioral health services. With telehealth services, you and your eligible family members can speak directly with a Blue Cross Blue Shield of Illinois (BCBSIL) network provider, Cigna network provider, or MyidealDoctor service provider via phone, tablet or computer.

The telehealth services provided through MyidealDoctor are already covered at 100%. However, in light of the restricted in-person access to medical and mental health treatment related to the COVID-19 health crisis, effective April 1, 2020, telehealth services for medically necessary treatment provided by BCBSIL and Cigna network providers will also be covered at 100%. This means that telehealth services provided by all in-network providers and MyidealDoctor service providers are **free.** You do not have to pay a copay or coinsurance, or meet a deductible in order to use the services. The 100% in-network telehealth coverage applies to all visits, regardless of whether they are or are not related to COVID-19.

Note that the expanded BCBSIL and Cigna telehealth coverage described above will extend through December 31, 2020, unless otherwise determined by the Board of Trustees or required under federal law. In addition, telehealth services received from out-of-network providers will continue to be paid in accordance with the Plan's out-of-network benefit provisions.

New Coverage for Gene Therapy

Effective July 1, 2020, the Plan will cover costs associated with gene therapy when the therapy has been approved by the U.S. Food and Drug Administration (FDA) and the Plan's medical management service provider has precertified that the therapy is medically necessary. Gene therapy that is considered experimental or investigational by the Plan will not be covered.

Coverage for gene therapy will be provided under the Plan's medical plan, not under the prescription drug benefit, and the Plan's deductible and coinsurance provisions will apply. Note that gene therapy typically involves 1) replacing a gene that causes a medical problem with one that does not; 2) adding genes to help the body fight or treat disease; or 3) turning off genes that cause medical problems. Examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) therapies, such as Kymriah and Yescarta, and other therapies like Luxturna and Zolgensma.

Final Note

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

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

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

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North Central Illinois Laborers' Health and Welfare Fund

Schedule of Benefits
July 1, 2020
BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$750 $1,500	$1,500 $4,500
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	Unlimited	
Penalty for Failure to Preauthorize Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care, and Transplant Benefits	$250 reduction in benefits	$250 reduction in benefits NOTE: the Plan does not cover out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care
Hospital Benefits (inpatient and outpatient) *Preauthorization of out-of-network Inpatient Hospital Services Required*	80%	50%
Outpatient Surgical Procedures[1] *Preauthorization Required*	80%; no deductible required	50%; no deductible required
Primary Care Doctor's Office Visits	$20 copay	50%
Specialist Office Visit	$50 copay	50%
X-Rays and Labs (including Pre-Admission Testing)	80%	50%
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Maternity Services	80%	50%
Urgent Care	80%	80%
Emergency Room	$200 copay	$200 copay
Ambulance Service	80%	80%
Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate		
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility Inpatient - Coinsurance - Calendar Year Maximum Outpatient - Coinsurance - Calendar Year Maximum	 80% if Medically Necessary 60 days per person 80% if Medically Necessary 60 visits per person (combined with out-of-network)	Out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care services are not covered, unless medical emergency, then paid at 50% 50% if Medically Necessary for outpatient services 60 visits per person (combined with in-network)
Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services		
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance *Preauthorization of Out-of-Network Inpatient Services Required – Call Medical Cost Management (MCM)* • *For a list of in-network providers, contact BCBSIL* • *For up to 6 free visits, contact the MAP provider listed on page 3*	 80% $20 copay office visit; no deductible required (outpatient only)	Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency, then paid at 50% 50% if Medically Necessary for outpatient services no deductible required (outpatient only)
Additional Surgical Opinion[1]	80%; no deductible required	50%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	50% (additional limitations apply)
Spinal Manipulation (Chiropractic or Medical) Calendar Year Maximum *Acupuncture included when Physician prescribed*	$15 copay per visit 60 treatments up to $1,000 (combined with out-of-network)	50% 60 treatments up to $1,000 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with out-of-network)	50% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	80% $500 (combined with out-of-network)	50% $500 (combined with in-network)

Medical Benefits	**In-Network (Illinois Providers Only)**	**Out-of-Network**
Other Covered Services, Radiation Therapy, Hospice Care and Gene Therapy *Preauthorization Required for Inpatient Hospice Care and Gene Therapy*	80%	50%
Treatment of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum	80% $1,000 (combined with out-of-network) $2,000 (combined with out-of-network)	50% $1,000 (combined with in-network) $2,000 (combined with in-network)
Smoking Cessation Benefits	80%	50%
Sav-Rx Prescription Drug Benefit	***Prescription drug benefits are only covered when filled at a participating pharmacy.***	
Out-of-Pocket Maximum - Individual - Family	$4,100 $5,700	
Retail Pharmacy Generic Medication Preferred Brand Name Medication Non-Preferred Brand Name Medication Specialty Medication	For up to a 34-day supply, you pay: 10% (minimum $10, maximum $20) 20% (minimum $20, maximum $50) 30% (minimum $35, maximum $125) 20% (minimum $20, maximum $50)	
Mail Order Pharmacy/Retail Maintenance Program Generic Medication Preferred Brand Name Medication Non-Preferred Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: 10% (minimum $20, maximum $40) 20% (minimum $50, maximum $100) 30% (minimum $100, maximum $250) 20% (minimum $50, maximum $100)	
Delta Dental of Illinois Dental Benefits [2]		
Calendar Year Deductible (*applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*)	$50 Individual/ $100 Family	
Dental Benefits Calendar Year Maximum	$1,500 [3]	
Type of Dental Services	**Delta Dental PPO Network[2]**	**Delta Dental Premier Network[2]**	**Out-of-Network[2]**
Preventive/Diagnostic Care Services Coinsurance paid by the Plan	100% of reduced fee (deductible applies)	100% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Primary (Basic) Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Major Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Orthodontia Benefits (only for eligible Dependent children under age 19) - Coinsurance paid by the Plan	50% of reduced fee	50% of maximum plan allowance	50% of maximum plan allowance
Vision Benefits	**Administered by Professional Benefit Administrators, Inc.**		
Covered Services	$250 per person per calendar year[3]		
Hearing Benefits	**Administered by Professional Benefit Administrators, Inc.**		
Hearing Benefits Lifetime Maximum	$5,000[4]		

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

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

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

4 The maximum does not apply toward hearing exams.

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

Continuing Eligibility For Eligibility A Employees

After you satisfy the initial eligibility requirements, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule:

If you work . . .	You will be eligible for Plan benefits during . . .
250 contribution hours in September, October, November; or 500 contribution hours in June through November; or 750 contribution hours in March through November; or 1,000 contribution hours in December through November.	January, February, and March
250 contribution hours in December, January, February; or 500 contribution hours in September through February; or 750 contribution hours in June through February; or 1,000 contribution hours in March through February.	April, May, and June
250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May.	July, August, and September
250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August.	October, November, and December

Contact Information

If you need information about	Contact	Contact Information
Eligibility, Life Insurance Benefits, and Accidental Death and Dismemberment Insurance Benefits	North Central Illinois Laborers' Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	866-692-0860 or 309-692-0860 [phone] 309-692-0862 [fax] ncil@ncil.us [e-mail] www.ncilhwf.com
Medical, Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax] www.pbaclaims.com
Blue Cross Blue Shield of Illinois Participating Providers	Blue Cross Blue Shield of Illinois	800-810-2583 [phone] www.bcbsil.com [web site]
Preauthorization ▪ Out-of-Network Inpatient Hospitalization, Outpatient Surgeries, Outpatient Rehabilitation, Habilitation, Inpatient Hospice Care and Transplant Benefits ▪ Out-of-Network Inpatient Mental Health and Substance Abuse Treatment ▪ Gene Therapy	Medical Cost Management	800-367-9938 [phone]
Member Assistance Plan (MAP)	Employee Resource Systems (ERS)	800-292-2780 [phone] www.ers-eap.com
Prescription Drug Benefits	Sav-Rx Mail Order P.O. Box 8 Fremont, NE 68026	800-228-3108 [phone] www.savrx.com [web site]
Dental Benefits	Delta Dental of Illinois P.O. Box 5402 Lisle, IL 60532 Group # 20141	800-323-1743 [phone] www.deltadentalil.com [web site]

Note: If you do not obtain Preauthorization when required, your benefits may be reduced.

North Central Illinois Laborers' Health and Welfare Fund

Schedule of Benefits
July 1, 2020
CIGNA Preferred Provider Organization (PPO) Plan

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$750 $1,500	$1,500 $4,500
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	Unlimited	
Penalty for Failure to Preauthorize Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care and Transplant Benefits	$250 reduction in benefits	$250 reduction in benefits NOTE: the Plan does not cover out-of network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation or Inpatient Habilitation care
Hospital Benefits (inpatient and outpatient) *Preauthorization of Out-of-Network Inpatient Hospital Services Required*	80%	50%
Outpatient Surgical Procedures[1] *Preauthorization Required*	80%; no deductible required	50%; no deductible required
Primary Care Doctor's Office Visits	$20 copay	50%
Specialist Office Visit	$50 copay	50%
X-Rays and Labs (including Pre-Admission Testing)	80%	50%
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Maternity Services	80%	50%
Urgent Care	80%	80%
Emergency Room	$200 copay	$200 copay
Ambulance Service	80%	80%
Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate		
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility Inpatient - Coinsurance - Calendar Year Maximum Outpatient - Coinsurance - Calendar Year Maximum	 80% 60 days per person 80% 60 visits per person (combined with out-of-network)	Out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care services are not covered, unless medical emergency, then paid at 50% 50% if Medically Necessary for outpatient services 60 visits per person (combined with in-network)
Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services		
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Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
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250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May.	July, August, and September
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Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax] www.pbaclaims.com
CIGNA Participating Providers	CIGNA c/o Professional Benefit Administrators, Inc. (PBA)	800-435-5694 www.mycigna.com [web site] (Member sign-in required)
Preauthorization ▪ Out-of-Network Inpatient Hospitalization, Outpatient surgeries, Outpatient Rehabilitation, Habilitation, Inpatient Hospice Care and Transplant Benefits ▪ Out-of-Network Inpatient Mental Health and Substance Abuse Benefits ▪ Gene Therapy	CIGNA c/o Professional Benefit Administrators, Inc. (PBA)	800-435-5694
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