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This notice contains important information regarding your Health Fund benefits

Date: April 15, 2020

To: Participants of the Connecticut Pipe Trades Health Fund

From: The Board of Trustees

This is an important notice describes important benefit changes that are being made to the Health Fund in reaction to COVID-19. Please read it carefully and share it with your family.

CHANGES TO THE PLAN IN REACTION TO COVID-19

By now, everyone has heard of the "Coronavirus" or the illness it causes, known as "COVID-19". At a time like this, it is more important than ever to have health insurance, and as a Participant in the Fund, we have you covered. Your health plan provides a wide range of benefits including but not limited to coverage for office visits, hospitalization and diagnostic testing (including testing for COVID-19). As always, we encourage you to use an In-Network Provider in order to receive the highest level of benefits.

If you and/or your dependents think you have been exposed to COVID-19 and develop a fever and/or symptom of respiratory illness, such as a cough or shortness of breath, call your healthcare provider immediately. We encourage you to call your healthcare provider before presenting to an emergency room for treatment, to both ensure you have the quickest access to the specific services you need as well as to prevent the unnecessary exposure of yourself and any other patients or providers in the emergency room to the coronavirus without having taken appropriate protective measures.

Waiver of Cost Sharing for Detection of COVID-19
Effective for services received on or after March 13, 2020 and through the end of the emergency period in which the federal government has announced a National Emergency, the Fund will now cover the following services **from either an In-Network or Out-of-Network provider with no cost-sharing (for example, no copayments, deductibles or coinsurance).**

- Diagnostic tests to detect the virus that causes COVID-19, including the administration of such tests, for the following types of tests:
  - Tests to detect the virus that are approved, cleared or authorized by certain sections of the Federal Food, Drug and Cosmetic Act (the Drug Act)
  - Tests for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied)
  - Tests developed in and authorized by a state that has notified HHS of its intention to review tests to diagnose COVID-19
  - Tests determined appropriate by HHS

- Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, one of the tests described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

These services will also be provided without any need for prior authorization or medical management. This means that you do not have to get precertification/prior authorization to have the tests or those visits covered. Payment for the treatment of COVID-19, including but not limited to hospital, transportation and pharmacy services will be covered in accordance with the terms and conditions set forth in the Summary Plan Description (SPD) and will still be subject to applicable cost-sharing.

Plan will Now Pay for Virtual or Telehealth Benefit

The Trustees are pleased to announce that the Plan will now cover virtual or telehealth visits provided by your own in-network physician (provided they have capabilities). Generally speaking, telehealth means the use of electronic information and communication technologies including a telephone, smartphone, tablet or computer with a web cam, by a physician or other licensed provider to deliver covered services from a location that is different from a provider's office.

Telehealth visits are a convenient way for you and your covered dependents to access care. The service gives you quick and easy access to a doctor wherever you are. You can talk to a physician without leaving your house. In fact, it is recommended that members use telehealth when possible to help prevent the spread of infection and improve access to care. It is a safe and effective way to receive medical guidance for many medical issues, including those related to COVID-19, from your home using your telephone or online (depending on your doctor).

Effective for services received on or after March 13, 2020 and through the end of the emergency period in which the federal government has announced a National Emergency, telehealth services (virtual visits) will be covered when provided by an In-network Provider at the current in-network copayment. The copayment will be waived for services related to testing for COVID-19 as described above.

If you wish to schedule a virtual visit with your own doctor or provider, check first to see if they offer telehealth services or virtual visits. If such services are available, the office can walk you through the process for scheduling an appointment and what types of virtual visits they provide (e.g., telephone or video). To locate a current listing of In-Network providers, visit www.anthem.com.

This benefit is not available for out-of-network providers (except as provided above for services related to testing for COVID-19).

If you have any questions regarding the information in this Notice, please contact the Fund Office.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan documents are at the Fund Office and may be inspected by you free of charge during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and/or factual, arising under the Plan.