AMENDMENT TO THE
SOUTHERN ILLINOIS LABORERS' & EMPLOYERS
HEALTH & WELFARE FUND SUMMARY PLAN DESCRIPTION

SUMMARY PLAN DESCRIPTION A – AMENDMENT #9
SUMMARY PLAN DESCRIPTION C – AMENDMENT #11

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fund may amend the Summary Plan Description ("SPD") pursuant to Article 13 of the Restated Agreement and Declaration of Trust; and

WHEREAS, the Board of Trustees has determined that the following revisions are necessary to clarify and amend provisions of the SPD; and

NOW THEREFORE, effective as of the below referenced dates, the following language revisions and additions are hereby approved and incorporated into the applicable sections of the Plan A and Plan C SPD's:

The following provision located in Article 1 of the SPD for Plan A and Plan C is hereby amended to read as follows effective July 1, 2025:

BENEFITS	IN-NETWORK (You will pay the least)	OUT-OF-NETWORK (You will pay the most)
SLEEP STUDY SEE SECTION 2.15 FOR ADDITIONAL REQUIREMENTS	80% AFTER DEDUCTIBLE $4,000 MAXIMUM PER SLEEP STUDY ONCE EVERY 5 YEARS $7,000 MAXIMUM PER SLEEP STUDY (UP TO 2 STUDIES) EVERY 5 YEARS FOR MINOR DEPENDENT CHILDREN UNDER AGE 12 IF TWO STUDIES REQUIRED	45% AFTER DEDUCTIBLE $4,000 MAXIMUM PER SLEEP STUDY ONCE EVERY 5 YEARS $7,000 MAXIMUM PER SLEEP STUDY (UP TO 2 STUDIES) EVERY 5 YEARS FOR MINOR DEPENDENT CHILDREN UNDER AGE 12 IF TWO STUDIES REQUIRED

The following provision located in Article 2, Section 2.15 of the SPD for Plan A and Plan C is hereby amended to read as follows effective July 1, 2025:

Section 2.15 Sleep Study

~~$4,000 maximum once every five years subject to a finding of Medical Necessity.~~

Sleep study coverage is subject to a finding of Medical Necessity and applicable co-payment and deductibles. See the Schedule of Benefits section of this Summary Plan Description for information regarding coverage maximums and limitations for the sleep study benefit.

The following provision located in Article 2, Section 2.20 of the SPD for Plan A and Plan C is hereby amended to read as follows effective January 1, 2026:

Section 2.20 Dental Benefits

The Plan provides dental benefits to help cover the cost of preventive, basic and major dental services received from licensed providers. Dental benefits are provided through the Delta Dental of Illinois network, a contracted provider that offers a comprehensive dental network to you and your eligible Dependents.

Delta Dental provides you with the ability to register online or download the Delta Dental mobile application to receive "real time" benefit information, check the status of your dental treatment claims, and to search for network providers in your area. Please visit www.deltadentalil.com or contact Delta Dental by phone at (800) 323-1743 for additional information.

Covered dental expenses are the expenses incurred by covered individuals for charges made by a Dentist for any dental service provided for in the Schedule of Benefits. The dental service must be performed by or under the direction of a Dentist and essential for the necessary care of the teeth. ~~, and begin while the individual is covered for dental expenses.~~

You may continue to utilize a Dentist that is not in the Delta Dental of Illinois network, however higher benefit levels generally apply when you obtain dental services from an in-network Delta Dental of Illinois participating Dentist. In the event you utilize an out-of-network Dentist, you will still need to present your Delta Dental ID card in order for the Fund Office to receive the claims for processing purposes. You may also submit out-of-network Dentist claims with a paid receipt (if applicable) via U.S. mail directly to the Fund Office at:

Southern Illinois Laborers' and Employers' Health & Welfare Fund
P.O. Box 40
Carterville, Illinois 62918

Note, if you submit a Dentist claim directly to the Fund Office, the claim paperwork must include claim treatment codes (often referred to as a "CDT" code) to enable the Fund to determine if the treatment is a Covered Service. Additional documentation may be required from you as well to enable the Fund to adjudicate the claim.

Covered dental expenses **will not** include:

1. Any expenses incurred for a dental service completed after the individual's dental expense benefits are terminated; or
2. Any charges which exceed the Reasonable and Customary charge for dental service.

CLASSIFICATION OF DENTAL SERVICES
Category A – Diagnostic/Preventive

1. Routine examinations	Once in any period of six (6) consecutive months.
2. Teeth cleaning	Once in any period of six (6) consecutive months.
3. Space maintainers	To replace prematurely lost teeth for Dependent children under age 19.
4. Topical fluoride/sealants application	Once in any period of twelve (12) consecutive

	months for Dependent children under age 19.
5. Emergency treatment for temporary relief of pain	
6. Dental x-rays including full mouth	Once is any period of thirty-six (36) consecutive months
7. Supplementary bitewing	Twice in any period of six (6) consecutive months

Pediatric Dental Care Benefits through age 18 will be provided according to the Schedule of Benefits and include the following:

1. A total of one oral cleaning and oral exam every six (6) consecutive months.

Category B – Dental Services – Basic Restorative – Endontic/Periodontics

1. Fillings	Amalgam, silicate, acrylic, synthetic porcelain or composite fillings
2. Extractions and Oral Surgery	
3. General Anesthetics	
4. Periodontal treatment of gums	
5. Endodontic treatment of the dental pulp, including root canal therapy	
6. Drugs for treatment of dental disease/Injury when administered by the attending Dentist.	

Category C – Major Restorative/Prosthodontics

1. Repair or recementing of crowns, inlays, onlays, bridgework, or dentures	No earlier than six (6) months after the installation
2. Relining or rebasing dentures	When performed more than six (6) months after the installation, but not more than once in twenty-four (24) months.
3. Inlays, onlays, gold fillings, or crown restoration	Only when the tooth cannot be restored with type of restoration fillings described above.
4. Prosthodontics	Includes attachments and adjustments during the six (6) months following the installation.
5. Replacement of or addition to existing bridgework or dentures	Only if the replacement of a bridge or denture is made more than five (5) years after the date of original installation unless: a. Replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or b. The bridge or denture, while in the oral cavity, has been damaged beyond repair by an Injury

sustained while covered Employee under dental Plan;

c. The replacement of or addition to existing bridgework or denture or the initial bridgework or dentures is made for a Participant of the Fund after continuous coverage during any consecutive twelve (12) month period.

Category D – Orthodontics

For those eligible Dependent children age six (6) through age eighteen (18), coverage for non-medically necessary orthodontics will be provided up to the Lifetime Maximum listed in the Schedule of Benefits.

DENTAL EXCLUSIONS AND LIMITATIONS

1. Expenses incurred solely for cosmetic reason will not be covered;

2. Dental care which is included as a covered expense under the Medical Benefit;

3. Covered dental expenses do not include and no benefits are provided for implants, oral hygiene instructions, broken appointments;

4. Charges for failure to keep a scheduled appointment with a Dentist.

5. Charges for the completion of insurance forms;

6. Duplicate charges that are due to the negligence of the patient;

7. Telephone charges;

8. No payment will be made for procedures which are not included in the list of covered dental services of the North American Dental Association Procedures or which are not necessary; and
9. Charges for services or supplies which are not generally accepted by the dental profession and are, in the Trustee's judgment, experimental or investigational are not covered by the Plan.

10. Treatment by other than a licensed Dentist, except charges by a licensed dental hygienist, under the supervision and direction of a Dentist.

~~**HOW TO OBTAIN DENTAL BENEFITS**~~

~~When filing a dental claim submit an itemized bill plus a paid receipt, if applicable. Mail to:~~

~~**Southern Illinois Laborers' & Employers' Health & Welfare Fund**~~

~~**Claims Department**~~

~~**5100 Ed Smith Way, Suite A**~~

~~**Marion, IL 62959**~~

IN WITNESS HEREOF, this Amendment has been approved and signed by the Board of Trustees on this 18th day of February 2026, to be effective as of the aforementioned date(s).

Todd Masterson
Chairman, Southern Illinois Laborers' and Employers Health & Welfare Fund

J. M. McPhail
Secretary, Southern Illinois Laborers' and Employers Health & Welfare Fund