Carpenters Local No. 491
Health & Welfare Fund

Board of Trustees Meeting

June 19, 2020

CARPENTERS LOCAL NO. 491
HEALTH AND WELFARE FUND
AGENDA
JUNE 19, 2020

A. ROLL CALL

B. MINUTES OF THE MARCH 20, 2020 AND MAY 1, 2020 BOARD MEETINGS

C. ADMINISTRATIVE REPORTS

1. Statement of Changes In Fund Balance (Jan - Mar, 2020)
2. Statement of Fund Balance (March 31, 2020)
3. Contribution / Claim Schedules (Jan - Mar, 2020)
4. Claim Payment Schedule (Jan - Mar, 2020)
5. Highest Cost Medical Claims (Jan - Mar, 2020)
6. Bills to be Approved and Paid (June 19, 2020)
7. Cash Management Statement

D. UNFINISHED BUSINESS

1. Delinquent Employer Listing
2. J.K. Cabinet
3. Payroll Audits
4. Update the Summary Plan Description
5. Buildtask 1st Amendment to Settlement Agreement
6. Updated Record Retention Policy

E. NEW BUSINESS

1. Bolton Partners Annual Report
2. Bolton Investment Report
3. Benefit Changes Cost Analysis
4. Express Scripts Rebates
5. Independence Administrators - Precertification and Appeals Process
6. Department of Labor - Extension of Timelines
7. PCORI Fees
8. 13th Amendment
9. Appeal
10. Questions
11. Date of Next Meeting - Sept., 2020

F. VACATION BENEFIT REPORT

CARPENTERS LOCAL NO. 491
HEALTH AND WELFARE PLAN
REGULAR MEETING OF THE BOARD OF TRUSTEES

March 20, 2020

MINUTES

A regular meeting of the Trustees of the Carpenters Local No. 491 Health and Welfare Plan was held at 10:20 a.m. on March 20, 2020, a via telephone conference call. Present on the call were the following Trustees:

UNION TRUSTEES	EMPLOYER TRUSTEES
Sandy Forstner	Ken Bisch
Bill Sproule	Mike Goodwin
Robert Tarby	Todd Weitzman

Also present by phone were Albert Kroll, Esq., Counsel for the Union; David J. Jensen, and Dawn Welch, Administrative Manager; Mark Lynne, of Bolton Partners, Inc.; Ira Marc Miller, CPA; Alton Fryer, of Bolton Partners Investment Consulting Group, Inc.; Pete Tonia; and Steven I. Batoff, Attorney.

The following matters were discussed with the indicated action taken:

1. The minutes of the meeting of December 18, 2019, were approved.
2. The Administrative Manager reviewed with the Trustees the Administrative Manager's report for the twelve months ending December 3,1 2019. The Fund balance as of December 31, 2019, was $9,994,087.98. The Administrative Manager reviewed with the Trustees the Fund balance report at market value as of December 31, 2019.

   The Administrative Manager then reviewed the claims payments for the December 2019 quarter and compared them to the March 2019, June 2019, and September 2019 quarters.

The Administrative Manager reported that there were no life insurance claims for the quarter ending December 31, 2019. The Administrative Manager reviewed the highest claim payments for the quarter. Upon motion duly made by Mr. Sproule and seconded by Mr. Tarby, the Administrative Manager's report was unanimously approved by the Trustees.

3. The Administrative Manager then reviewed with the Trustees the bills to be paid, as listed in an attachment to these minutes. The Trustees, upon motion duly made by Mr. Goodwin and seconded by Mr. Sproule, unanimously approved payment of the aforementioned checks.

4. The following Delinquent Contractor Listing was reviewed by the Trustees and the Administrative Manager:

J.K. Cabinet Co., Inc.	10/16-11/16

The Trustees then discussed the delinquent employer with Mr. Batoff and the Administrative Manager.

Mr. Batoff reported that J.K. Cabinet Co., Inc. is delinquent in paying the amounts it agreed to pay to the Plan. Mr. Batoff, upon inquiry to J.K. Cabinet's counsel, was informed that the company has no business. The Administrative Manager reported that the company owes the Plans approximately $7,600 in contributions.

5. The Administrative Manager reviewed with the Trustees the cash management statement.

6. Mr. Lynne then reviewed with the Trustees the projected versus actual budget for the twelve months ended December 31, 2019. He also reviewed a history of quarterly contributions (net of reciprocals) for 2015, 2016, 2017, 2018, and 2019.

7. Dawn Welch then reviewed with the Trustees the ESI-HIV Care Value program. Ms. Welch noted that this program is provided through no cost to members and no charge by Express Scripts, Inc. Mr. Lynne recommended that the Trustees participate in this program. Upon motion duly made by Mr. Tarby and seconded by Ms. Forstner, the Trustees unanimously approved program participation.

Ms. Welch then discussed the subrogation services of the Phia Group. She noted in particular that the Phia Group gets a fee equal to 15 percent of whatever it recovers. Upon motion duly made by Mr. Sproule and seconded by Mr. Weitzman, the Trustees unanimously agreed to retain of the Phia Group, subject to Mr. Batoff's review of its contract.

8. Alton Fryer, of Bolton Partners Investment Consulting Group, Inc., then reviewed the quarterly review of the Fund as of December 31, 2019. Mr. Fryer then provided a review of the economy and capital markets. He then reviewed asset allocation; asset reconciliation; long term asset growth; portfolio targets; historical performance; calendar year performance; and 3-year risk/reward summary, 5-year risk/reward summary, and 10-year risk/reward summary. He then reviewed calendar year-to-date returns for various investments and their respective benchmark.

He also reviewed the asset allocation as of March 8, 2020.

9. Mr. Lynne then recommended that the Trustees consider telemed and work with Independence Administrators to implement telemed and for the Administrative Manager to coordinate with Pete Tonia and Independence Administrators. Upon motion duly made by Mr. Weitzman and seconded by Mr. Tarby, the Trustees unanimously agreed to implement telemed.

10. Dawn Welch then gave a verbal report to the Trustees as to demographics of claims. Ms. Welch also provided a written report as to demographics of claims.

11. The Administrative Manager, Pete Tonia, Mr. Batoff, the Trustees, and Ira Miller, of Ira Marc Miller & Co., P.A., then discussed with the Trustees payroll audits. The Trustees then reviewed the payroll audit update provided by Mr. Tonia. The Trustees then discussed Alliance Expo and Brede. Mr. Miller reported that he had successfully completed the payroll audit of Brede. Dave Jensen provided an updated report from David Letushko. In reviewing the report, Mr. Jensen noted that Reber Friel's payroll audit is complete, with discrepancies found. The report was forwarded on January 3, 2020, to Reber Friel.

12. Ms. Welch then reviewed the Express Scripts rebates.

13. Mr. Batoff updated the Trustees as to the status of the updated summary plan description. Mr. Batoff informed the Trustees that his firm had completed the updated summary plan description, which had been reviewed by the Administrative Manager. He noted that he is waiting for claims procedures from Independence Administrators before he can complete the updated summary plan description.

14. Dawn Welch then discussed with the Trustees the CareFirst of Maryland network access agreement run-out administrative fee. Ms. Welch stated that claims are still coming in for those incurred before the January 1, 2020, switch to Level Care/Independence Administrators.

15. Dawn Welch then discussed with the Trustees the Level funds appeal process. Mr. Batoff stated that under ERISA it was his opinion that the Trustees should reserve the ultimate say in granting or denying an appeal. The Trustees requested that the

Administrative Manager and Pete Tonia note this point when they discuss with Level Care/Independence Administrators the Level funds appeals process.

Ms. Welch then discussed with the Trustees mental health and substance abuse outpatient precertification. The Trustees tabled any action on this matter and requested that the Administrative Manager, working with Pete Tonia and Marc Lynne, discuss this matter with Independence Administrators.

16. Mr. Batoff then discussed at great length with the Trustees the Families First Coronavirus Response Act. Mr. Batoff reviewed with the Trustees the required amendments to the Plan under the Act. Mr. Batoff also noted that prior to the telephone conference he had e-mailed to the Trustees and the Administrative Manager possible options to amend the Plan to assist members regarding their benefits under the Plan.

The Trustees, upon motion duly made by Mr. Sproule and seconded by Ms. Forstner, unanimously agreed to amend the Plan, effective April 1, 2020, as follows:

- Effective April 1, 2020, deductibles are waived until December 31, 2020.
- Effective April 1, 2020, copayments are waived until June 30, 2020.
- If participants were eligible for benefits under the existing Plan rules for the work quarter for October through December 2019, they are automatically eligible for the benefit quarter under the Plan for the April through June 2020 benefit quarter. If participants were eligible for benefits under the existing Plan rules for the benefit quarter April through June 2020, they will be automatically eligible for benefits under the Plan benefit quarter for July through September 2020.

The Trustees requested that the Administrative Manager and Mr. Lynne do a cost analysis regarding the aforementioned changes to the Plan. The Trustees also requested

that Mr. Batoff prepare the necessary amendment to the Plan and summary of material modifications to implement the aforementioned and for the Administrative Manager distribute to participants the summary of material modifications.

17. Mr. Batoff reported that he will e-mail to all the Trustees conflict of interest forms and gift policy forms for 2020. Mr. Batoff requested that the Trustees sign and date the forms and send them back to him and the Administrative Manager via e-mail.

18. The Administrative Manager reported an appeal by a participant who wants to obtain his maintenance medications at a retail pharmacy instead of through the Plan's mandatory mail-order program. The Administrative Manager contacted Express Scripts, which advised that the participant is currently receiving three maintenance medications through the mail-order program. The Administrative Manager stated that in accordance with Plan rules maintenance medications must be obtained through the mail-order program or they will not be covered. Upon motion duly made by Mr. Tarby and seconded by Mr. Sproule, the Trustees unanimously agreed to deny the appeal because, under the Plan, maintenance medications must be obtained through the mail-order program. The Trustees requested that the Administrative Manager so inform the provider and the participant of the denial of the appeal in accordance with ERISA and the Plan's claims/appeals procedures.

19. The Administrative Manager reviewed with the Trustees the Member XG-New Service to Access Your Benefits Online Portal.

20. On behalf of Associated Administrators, LLC, David Jensen then discussed with the Trustees and Mr. Batoff the renewal of the contract between the Fund and Associated Administrators, LLC. The Trustees recommended that Mr. Batoff review the contract

and compare the fees and services to those set forth by Associated Administrators in its response to the request for proposal.

21. The Administrative Manager reported that the fiduciary liability insurance policy with Ullico Organized Labor Protection Group, LLC was renewed for a one-year period, beginning March 15, 2020.

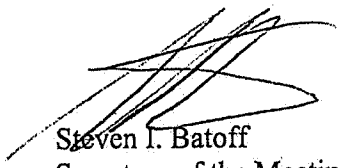
22. Mr. Batoff updated the Trustees as to the new U.S. Department of Labor electronic disclosure regulations. After a thorough review of the regulations, Mr. Batoff stated that the Plan's record retention policy would need extensive revision. Upon motion duly made by Mr. Weitzman and seconded by Mr. Tarby, the Trustees unanimously agreed that Mr. Batoff should update the Plan's record retention policy.

23. The Administrative Manager informed the Trustees that the Annual Patient Centered Outcome Research Institute fees have been extended through September 30, 2029.

24. The Trustees then reviewed with the Administrative Manager the cash balance report for the vacation benefit for the twelve months ending December 31, 2019. The cash balance as of December 31, 2019, was $244,400.89. The Trustees, upon motion duly made by Ms. Forstner and seconded by Mr. Sproule, unanimously agreed that, in light of the unemployment of most members participating in the vacation benefit, the Administrative Manager is to distribute as soon as possible all monies received for vacation benefits for hours worked through February 29, 2020, with the balance to be distributed in normal fashion.

There being no further business, the meeting was thereupon adjourned at 12:05 p.m. with next regular meeting scheduled for June 19, 2020, at 9:00 a.m.

Respectfully submitted,



Steven I. Batoff
Secretary of the Meeting

CARPENTERS LOCAL NO. 491

ANNUITY PLAN
HEALTH AND WELFARE PLAN
PENSION PLAN

May 1, 2020

MINUTES

A conference call of the Trustees of the Carpenters Local No. 491 Annuity Plan, Carpenters Local No. 491 Health and Welfare Plan, and Carpenters Local No. 491 Pension Plan was held via telephone call at 2:00 p.m. on May 1, 2020. Present on the call were the following Trustees:

UNION TRUSTEES	EMPLOYER TRUSTEES
Sandra Forstner	Ken Bisch was absent
William Sproule	D. Michael Goodwin
Robert Tarby	Todd Weitzman

Also present on the call were David J. Jensen and Dawn Welch, Administrative Managers; Alton D. Fryer IV, AIF, of Bolton Partners Investment Consulting Group, Inc.; and Steven I. Batoff, Attorney.

The following matters were discussed with the indicated action taken:

1. Alton D. Fryer IV, AIF, of Bolton Partners Investment Consulting Group, Inc., reviewed his April 28, 2020, email to the Trustees regarding his recommendation that the Carpenters Local No. 491 Annuity Plan (the "Annuity Plan") reallocate its assets in order to better manage participant redemptions from the investment account. In his review of his email, Mr. Fryer stated that, in light of the recently adopted Fifth Amendment to the Annuity Plan, the Annuity Plan has experienced $1.5 million in redemptions from the

investment account in April 2020, and that he anticipates more in the coming months before the temporary provisions related to loans requested to pay for emergency expenses arising out of the recent COVID-19 pandemic expire at the end of June 2020. Mr. Fryer's review of his email continued by recommending that, in an effort to get ahead of the redemptions, and take advantage of a run up in equities of over 10% since late March 2020, the Annuity Plan implement a temporary adjustment of its target allocation for the Annuity Plan. Mr. Fryer explained that the Annuity Plan currently targets 50% in equities and 50% in fixed income, with no target for cash. In light of the increase in redemptions, Mr. Fryer recommends adjusting to a 45% target for equities, 50% in fixed income, and 5% in cash until July 1, 2020, when the applicable Annuity Plan provisions sunset. Mr. Fryer further explained that these targets stay within the bounds of the Annuity Plan's Investment Policy Statement, but that they ensure that the Annuity Plan will have cash on hand to pay benefits without being forced to redeem further from equities in potentially difficult market conditions. Mr. Fryer noted that if the Annuity Plan has the assets in the money market (cash) account at the Custodian, that will make it easier for the Administrative Manager to ensure that it can pay benefits as quickly as possible. Additionally, according to Mr. Fryer, as of April 27, 2020, the Annuity Plan's assets had a market value of $43.3 million, so a 5% position would put about $2.2 million in cash. Mr. Fryer suggested implementing his recommendation by reducing the equity exposure by selling from the Vanguard Institutional Index, which is currently up about 10% since March 31, 2020, and is the most overweight of the equity assets, and stated that future trades to maintain this allocation would be made from the most overweight asset based on the temporary allocation targets. Mr. Jensen added that 194 applications for loans related

to the COVID-19 pandemic have been processed, for an estimated $896,000. The Trustees, upon motion duly made by Mr. Tarby and seconded by Mr. Goodwin, unanimously approved adjusting asset allocations in accordance with Mr. Fryer's recommendation.

2. Mr. Fryer then reviewed the updated monthly asset valuation report for the Annuity Plan, the Carpenters Local No. 491 Health and Welfare Plan, and the Carpenters Local No. 491 Pension Plan (collectively, the "Plans").

3. COVID-19-related distributions to in-service participants pursuant to the CARES Act were then discussed. Under this optional change, plans are permitted to allow COVID-19 distributions during 2020 of up to $100,000 from the vested benefit of a "qualified participant." Because this is optional, a plan can choose to limit the distribution to an amount that is less than $100,000. This applies to both defined contribution plans and defined benefit pension plans. However, defined benefit pension plans may not allow an in-service distribution prior to age 59-and-a-half, and would be required to be amended to permit in-service distributions if this option is extended to active employees. Any distribution during calendar year 2020 can qualify for treatment as a COVID-19 distribution. Qualified participants may elect a COVID-19 distribution for up to $100,000 during 2020 as long as the participant self-certifies that the participant is a "qualified participants." If the distribution is made prior to age 59-and-a-half, it is not subject to the 10% early withdrawal penalty that normally applies to distribution made to participants prior to age 59-and-a-half. The distributions also are not subject to mandatory 20% federal tax withholding. The distribution is includible in a participant's 2020 income, but the participant may include the distribution in income ratably over the 2020 through 2022

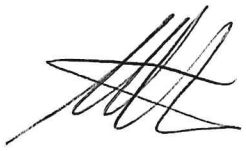
tax years. The participant can also repay the distribution to the plan within three years of the date of the distribution, and the repayment will be treated as a rollover contribution to the plan and will not count against any contribution limits for that year. The Trustees took no action.

4. Mr. Tarby then discussed his correspondence with Buildtask, LLC d/b/a Positive-ID ("Buildtask") regarding Buildtask's obligations to the Plans and affiliates of the Plans pursuant to the Settlement and Conditional Release Agreement executed November 1, 2019. Mr. Tarby relayed Buildtask's request to temporarily suspend Buildtask's obligations to the Plans and affiliates of the Plans pursuant to said Settlement and Conditional Release Agreement for the months of May (a payment of $3,152.25 to the Plans and affiliates of the Plans), June (a payment of $3,152.25 to the Plans and affiliates of the Plans), July (a payment of $3,152.25 to the Plans and affiliates of the Plans), and August (a payment of $3,152.25 to the Plans and affiliates of the Plans) of 2020, and to resume its obligations to the Plans and affiliates of the Plans beginning September 2020. Buildtask's request, made in response to the COVID-19 pandemic, was deemed reasonable by the Trustees. The Trustees, upon motion duly made by Mr. Tarby and seconded by Mr. Goodwin, unanimously approved Buildtask's request to temporarily suspend its obligations to the Plans and affiliates of the Plans for the months of May, June, July, and August of 2020, and agreed that Buildtask's obligations to the Plans and affiliates of the Plans for those months be added to end of the payment schedule of Section G of the Settlement and Conditional Release Agreement executed November 1, 2019. The Trustees requested that Mr. Batoff prepare any such amendment to said

Settlement and Conditional Release Agreement in order to implement this change, as is deemed necessary.

There being no further business, the conference was thereupon adjourned at 2:38 p.m.

Respectfully submitted,



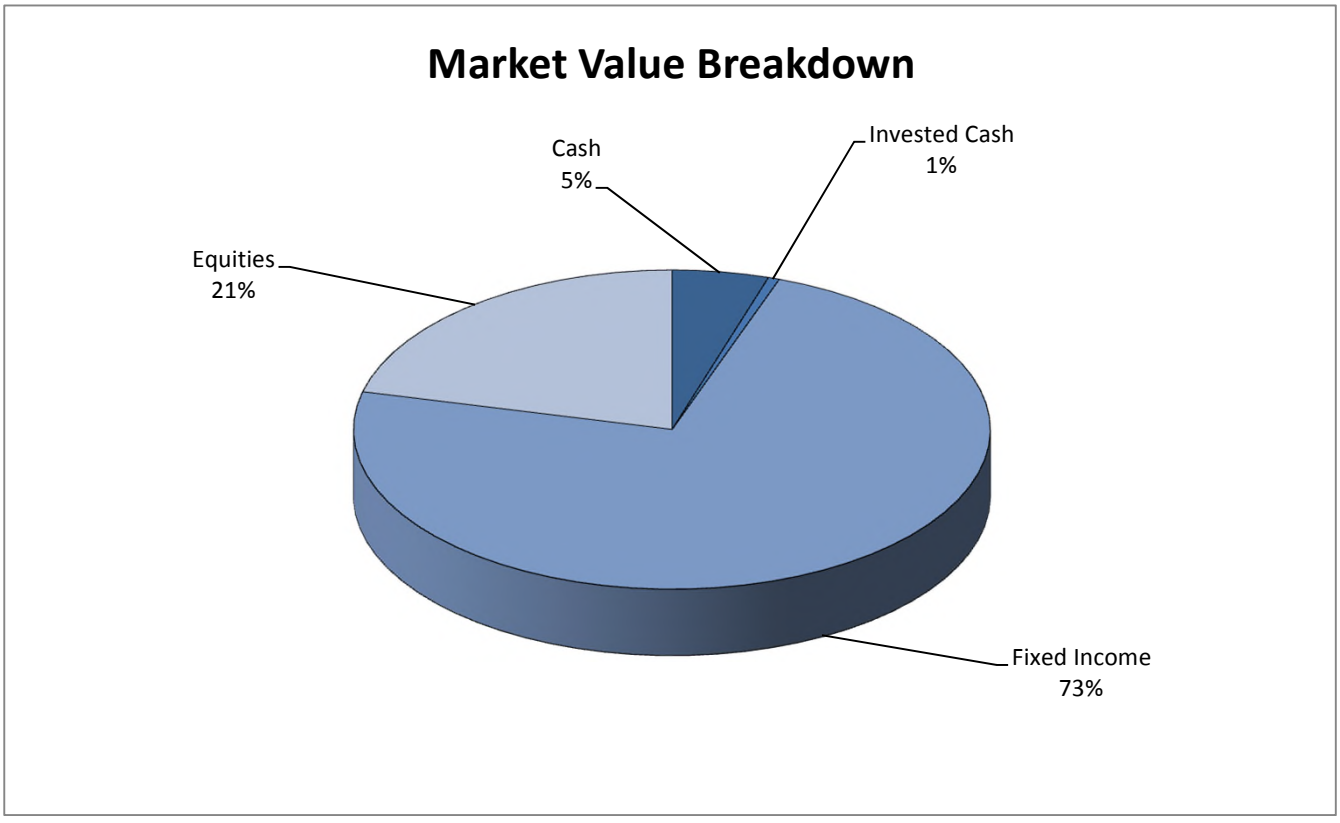
Steven I. Batoff

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
STATEMENT OF CHANGES IN FUND BALANCE - CASH BASIS
FOR THE THREE MONTHS ENDED MARCH 31, 2020

	Current Quarter	Year To Date
Additions		
Employer/Employee Contributions	$ 865,169.67	$ 865,169.67
Dividends	61,510.44	61,510.44
Interest	584.34	584.34
Rebates	-	-
Gain (Loss) on Sale of Investments	181.49	181.49
Securities Litigation Proceeds/Unclaimed Prop.	-	-
Total Additions	927,445.94	927,445.94
Deductions		
Medical Deductions	717,702.50	717,702.50
P.P.O. Fees	2,739.96	2,739.96
Dental Premium	3,823.08	3,823.08
Claims - IHA	192,003.33	192,003.33
PCORI Fee	-	-
ESI-FWA Fee	-	-
Actuarial Fees	5,000.00	5,000.00
Administration - AA LLC	33,928.00	33,928.00
Administration - IHA	44,145.30	44,145.30
HIPPA Compliance Fees	-	-
Computer Expenses	-	-
Conference Expenses	2,212.26	2,212.26
Reciprocals Paid	46,546.46	46,546.46
Audit Fees	-	-
Investment Manager Fees	530.00	530.00
Investment Performance Fees	625.00	625.00
Meeting Expense	112.33	112.33
Medical Consultant Fees	-	-
Dues	-	-
Employer Audits	7,265.69	7,265.69
Fidelity Bond	500.00	500.00
Cyber Liability Insurance	-	-
Fiduciary Liability Insurance	6,287.98	6,287.98
Independent Fiduciary Fee	381.25	381.25
Stop Loss Insurance	63,801.66	63,801.66
Stop Loss Reimbursement	-	-
Pharmacy Consulting	-	-
Office Expenses	60.00	60.00
Postage	901.00	901.00
Legal Fees	31,708.75	31,708.75
Printing	562.46	562.46
Hospital Reviews	17,462.66	17,462.66
Hospital Audits	-	-
Trustee Fees	-	-
Consulting Fees	-	-
Bank Service Charges	20,081.03	20,081.03
Transitional Reinsurance Fee	-	-
Settlement	-	-
Total Deductions	1,198,380.70	1,198,380.70
Net Increase (Decrease)	$ (270,934.76)	$ (270,934.76)
Fund Balance - December 31, 2019		9,994,087.98
Fund Balance - March 31, 2020		$ 9,723,153.22

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
STATEMENT OF FUND BALANCE
AS OF MARCH 31, 2020

	Cost Basis	Market Basis
Bank of America		
Cash - Operating	$ 544,722.49	$ 544,722.49
Cash - Benefit	(59,515.48)	(59,515.48)
	485,207.01	485,207.01
Amalgamated Bank of Chicago		
Cash & Cash Equivalents	-	-
Money Market	56,663.81	56,663.81
Fixed Income	7,091,240.11	7,270,270.49
Equities	2,028,989.87	2,102,481.16
	9,176,893.79	9,429,415.46
Other Assets & Payables (Net)	52.42	52.42
Independent Health Deposit	61,000.00	61,000.00
	$ 9,723,153.22	$ 9,975,674.89
Market Value of Fund Balance as of December 31, 2019		10,837,077.19
Change in Market Value of Fund as of December 31, 2019		$ (861,402.30)
Decrease in Cash		(270,934.76)
Unrealized Loss on Investments		(590,467.54)
		$ (861,402.30)



CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
CONTRIBUTIONS / CLAIMS SCHEDULES
FOR THE THREE MONTHS ENDED MARCH 31, 2020

Employer Contributions

Hourly rates and their effective dates

Date	Shops	Exhibitors
03/01/05	2.30	3.00
03/01/06	2.30	3.25
07/17/06	2.40	3.25
03/01/07	2.40	3.55
07/17/07	2.50	3.55
01/17/08	2.60	3.55
03/01/08	2.60	3.80
07/17/08	2.70	3.80
01/17/09	2.80	3.80
03/01/09	2.80	4.15
03/01/10	2.80	4.45
03/01/11	2.80	4.60
07/17/11	3.00	4.60
03/01/12	3.00	5.00
03/01/13	3.00	5.25
03/01/14	3.15	5.60
03/01/14	3.40	5.60
03/01/15	3.40	5.85
07/20/15	3.50	5.85

Employer / Employee

Prior Years Analysis

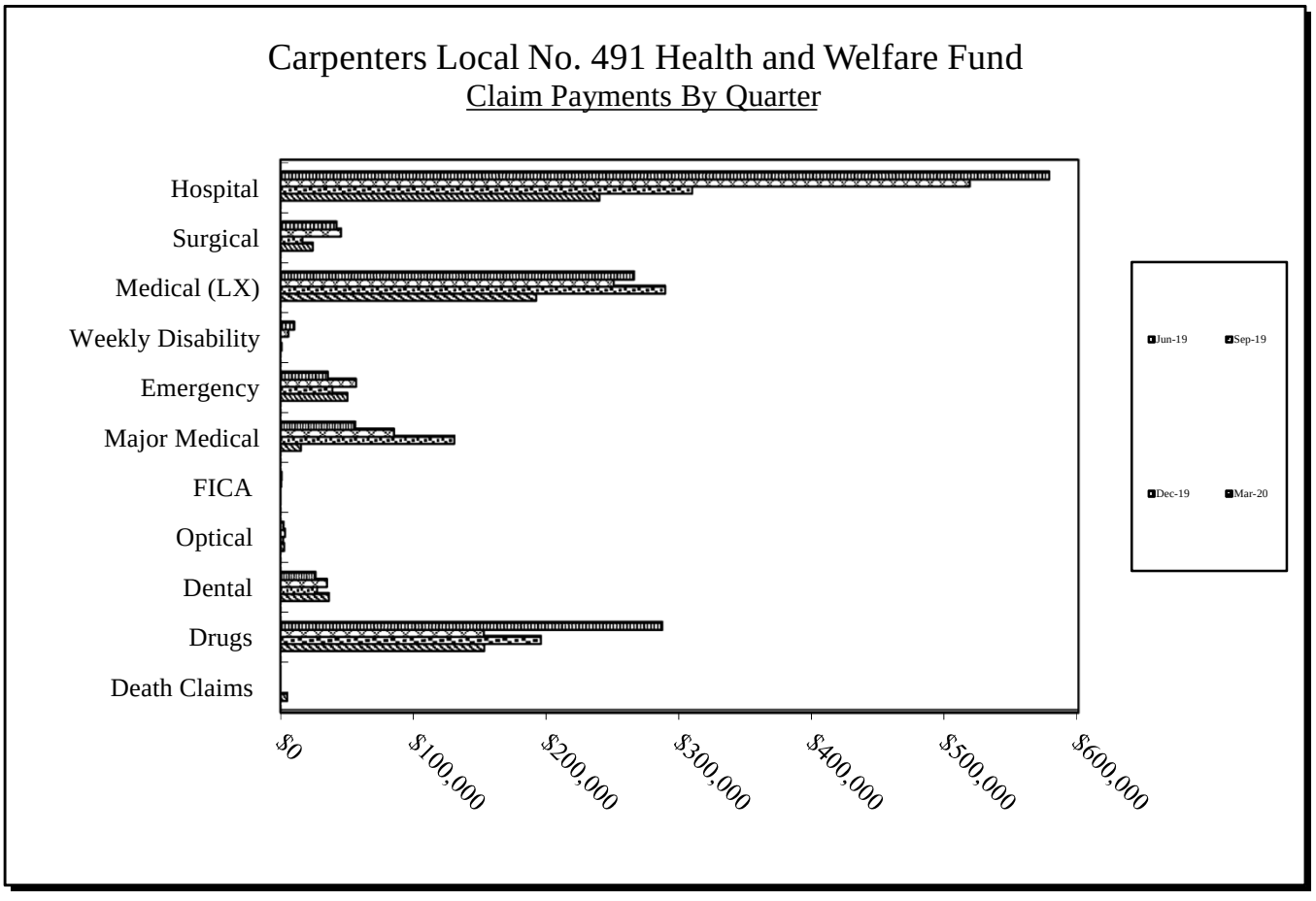
Year	Receipts	Claims	Difference
2010	$ 3,156,780.29	$ 2,625,943.50	$ 530,836.79
2011	3,879,294.58	3,234,111.38	645,183.20
2012	3,819,855.24	3,778,361.78	41,493.46
2013	4,049,717.46	3,202,012.09	847,705.37
2014	4,262,555.33	3,252,072.12	1,010,483.21
2015	4,501,646.07	2,728,405.47	1,773,240.60
2016	4,881,298.31	2,918,759.70	1,962,538.61
2017	5,049,927.78	2,915,661.88	2,134,265.90
2018	4,793,825.81	3,650,944.24	1,142,881.57
2019	4,818,837.41	4,379,457.69	439,379.72
2020	865,169.67	909,705.83	(44,536.16)

Current Year Analysis

Month	Receipts	Claims	Difference
January	$ 279,813.65	$ 346,048.41	$ (66,234.76)
February	$ 319,456.53	$ 271,332.52	48,124.01
March	$ 265,899.49	$ 292,324.90	(26,425.41)
April			-
May			-
June			-
July			-
August			-
September			-
October			-
November			-
December			-
	$ 865,169.67	$ 909,705.83	$ (44,536.16)
Average Per Month	$ 288,389.89	$ 303,235.28	$ (3,711.35)

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
CLAIM PAYMENT SCHEDULE
FOR THE THREE MONTHS ENDED MARCH 31, 2020

Claim Payments	Jun-19 Quarter	Sep-19 Quarter	Dec-19 Quarter	Mar-20 Quarter
Hospital	$ 577,669.98	$ 517,321.61	$ 308,606.91	$ 239,076.31
Surgical	41,924.50	45,355.09	16,433.29	24,137.14
Medical (LX)	265,008.68	249,653.00	288,292.75	191,618.62
Weekly Disability	10,285.78	5,914.32	0.02	771.44
Emergency	35,542.76	56,635.43	38,894.33	50,060.65
Major Medical	56,005.32	85,032.31	130,237.28	15,279.50
FICA	786.85	452.43	0.02	59.02
	987,223.87	960,364.19	782,464.60	521,002.68
Optical	2,274.90	3,380.62	1,929.88	2,723.16
Dental	26,290.12	34,885.09	27,411.13	36,247.08
Drugs	286,166.89	152,321.27	195,187.33	152,729.58
	314,731.91	190,586.98	224,528.34	191,699.82
Death Claims	-	-	-	5,000.00
	$ 1,301,955.78	$ 1,150,951.17	$ 1,006,992.94	$ 717,702.50
IHA Claims	-	-	-	192,003.33
	$ 1,301,955.78	$ 1,150,951.17	$ 1,006,992.94	$ 909,705.83



CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN
HIGHEST COST MEDICAL CLAIMS
June 19, 2020

Highest Individual Claim Expense January 1, 2020 to March 31, 2020

Patient	Illness	Medical	Hospital	Total
Member	Alcohol Dependence	$ 160.23	$ 92,425.00	$ 92,585.23
Member	Alcohol Dependence	0.00	64,112.45	64,112.45
Spouse	Rotator Cuff Repair	351.56	65,773.85	66,125.41
Spouse	Liver Cancer	2,843.99	31,294.66	34,138.65
Member	Tongue Cander	1,350.03	28,985.40	30,335.43
Member	Morbid Obesity	1,840.18	20,514.23	22,354.41
Member	Colon Cancer	21,850.89	0.00	21,850.89
Spouse	Gestational Diabetes	3,773.74	12,782.86	16,556.60
Son	Asthma	2,755.01	13,649.62	16,404.63
Daughter	Inguinal Hernia	2,805.90	12,470.04	15,275.94
Spouse	Lung Cancer	13,654.95	0.00	13,654.95
Spouse	Lung Cancer	11,836.23	0.00	11,836.23
Spouse	Postpartum Hemorrhage	330.83	9,592.21	9,923.04
Member	Gastritis	0.00	8,335.34	8,335.34
Member	Prostate Cancer	1,147.83	5,119.09	6,266.92
Member	Hematuria	1,889.54	3,187.44	5,076.98
	Total	**$ 66,590.91**	**$ 368,242.19**	**$ 434,833.10**

Life Insurance Claims Paid January - March 2020

No Death Benefits Processed This Quarter

Monthly Paid Prescription Drug Cost

January	$ 40,805.61
February	68,924.67
March	72,571.15
	$ 182,301.43

Individual High Claimant Report - Medical Only

Independence
Independence Administrators

Current Period: Paid - 01/2020 to 03/2020 | Compared to: Paid - 01/2020 to 03/2020

Key Metrics (Medical Only)

Threshold:	$20,000
High Cost Claimants:	2
High Cost Claimant Total Payment:	$61,563

ID	Member Number	Status	Term Date	Prior Period HCC	Prior Period Net Payment	Effective date of continuous enrollment	Age	Gender	Relationship	Inpatient Net Payment	Outpatient Net Payment	Professional Net Payment	Total Medical Net Payment	Condition	Inpatient Admits
1	31791027	Active	N/A	Yes	$37,494	202001	67	Female	Spouse	$0	$0	$37,494	$37,494	Coagulation And Hemorrhagic Disorders [62.]	0
2	31784998	Active	N/A	Yes	$24,070	202001	65	Male	Subscriber	$0	$2,562	$21,508	$24,070	Other Gastrointestinal Cancer	0

Note: This report should not be used for stop loss purposes

Client: LEVEL CARE HEALTH| Request Id: 93695 | File Name: hcc 491_Quarterly Impact of HCC_93695.xlsx| Created:Friday, 6/12/2020 4:00:17 PM

This information is proprietary and confidential. Results are not guaranteed to match billing and/or rating statements.

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
BILLS TO BE APPROVED AND PAID
OPERATING ACCOUNT
June 19, 2020

Payee/Purpose	Period	Check #	Amount
1. Washington Area Carpenters' Fund Reciprocal Hours	2/20	3460	7,137.06
2. Schmitz & Sons, Inc. Postage - COVID - 19 SMM Letters	3/20	3461	234.50
3. Associated Administrators, LLC 2nd Quarter Administration Fee	4/20 - 6/20	3462	31,250.00
4. Associated Administrators, LLC Printing - QSR's & Signature Stamp	3/20	3463	114.90
5. American Health Holding, Inc. Monthly Review Fee	3/20	3464	692.49
6. American Health Holding, Inc. Case Management Review	2/20	3465	204.00
7. Batoff Associates, P.A. Legal Fees	3/20	3466	16,953.15
8. Chason, Rosner, Leary & Marshall, LLC Legal Fees - JK Cabinet	2/20-3/20	3467	76.35
9. CIGNA Dental Health, Inc. Dental Premium	4/20	3468	1,257.56
10. Union Labor Life Insurance Company Stop Loss Insurance Premium	4/20	3469	22,410.18
11. Batoff Associates, P.A. Legal Fees	4/20	3470	3,967.50
12. Custom Plastic Card Company Printing - Dental Cards		3471	554.00
13. Associated Administrators, LLC Postage - Vacation Checks	4/20	3472	437.50
14. Void		3473	-
15. Schmitz & Sons, Inc. Printing - COVID-19 Letters		3474	358.50
16. Asmed Health , LLC Hospital Reviews - Batch #216		3475	14,383.19

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
BILLS TO BE APPROVED AND PAID
OPERATING ACCOUNT
June 19, 2020

	Payee/Purpose	Period	Check #	Amount
17.	Washington Area Carpenters' Fund Reciprocal Hours	3/20	3476	8,254.45
18.	CIGNA Dental Health, Inc. Dental Premium	5/20	3477	1,463.18
19.	Union Labor Life Insurance Company Stop Loss Insurance Premium	5/20	3478	22,777.56
20.	Schmitz & Sons, Inc. Postage - QSR's		3479	127.83
21.	Associated Administrators, LLC Printing - Envelopes		3480	82.01
22.	Asmed Health, Inc. Hospital Reviews - Batch # 217 & 218		3481	5,769.85
23.	Batoff Associates, P.A. Legal Fees	5/20	3482	5,968.50
24.	Bolton Partners, Inc. Investment Performance Fees	1/20 - 3/20	3483	750.00
25.	Bolton Partners, Inc. Actuarial & Consulting Fees	1/20 - 3/20	3484	5,000.00
26.	Washington Area Carpenters' Fund Reciprocal Hours	3/20	3485	23.40
27.	CIGNA Dental Health, Inc. Dental Premium	6/20	3486	1,454.24
28.	Union Labor Life Insurance Company Stop Loss Premium	6/20	3487	22,818.38
				$ 174,520.28

Carpenters Local 491 Benefit Funds
Cash Management

		Medical
Yearly Deductions		$ 5,360,062
Loans per Year		
Total Yearly Deductions		
10% of Expenses		$ 536,006
Current Cash Balance	As of 4/30/20	$ 706,645
5% Floor		$ 268,003
Replenish		Not now
15% Ceiling		$ 804,009
Send to Amalgamated		**Not now**
Transfer Made:	Jun-17-20	$ -

CARPENTERS DELINQUENCY LIST
AS OF
MARCH 20, 2020

1) If Local has "X" in a block, please indicate "Worked" or "No Men"
2) Please fax updates to Ramona at 410-683-7794

EMP #	See Instructions Above Balt.	Wash.	COMPANY NAME	WORK MONTHS DELINQ.
453			J.K. CABINET CO., INC.	10/16 - 11/16

Carpenters Local No. 491 Health and Welfare Plan

Record Retention Policy

The Trustees of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") have adopted the following Policy with respect to the maintenance of Plan records, reports, and documents in accordance with the Employee Retirement Income Security Act of 1974 ("ERISA") and other applicable federal law.

Record Retention & Maintenance Generally

In general, the Plan will maintain records of copies of any reports filed and of documents associated with the filing of any reports for a period of not less than six (6) years. The Plan will maintain records with respect to each Participant in the Plan (and, where appropriate, each spouse, dependent, beneficiary, and alternate payee, collectively referred to herein as "Participant") sufficient to determine the benefits due or which may become due to such Participants indefinitely, or for as long as they may be relevant to a determination of benefit entitlements, but not for a period of less than six (6) years.

The Plan will maintain copies of the original signed Plan Document and any amendments thereto, the Trust Agreement and any amendments thereto, the Summary Plan Description, and any and all determination letter rulings or other communications received from the Internal Revenue Service ("IRS"), the Department of Labor ("DOL"), or other federal or state agency.

DRAFT

The Plan may use electronic media to maintain records in accordance with this Policy if the following criteria are met:

(1) The electronic recordkeeping system has reasonable controls to ensure the integrity, accuracy, authenticity, and reliability of the records kept in electronic form;

(2) The electronic records are maintained in reasonable order and in a safe and accessible place, and in such manner as they may be readily inspected or examined (for example, the recordkeeping system should be capable of indexing, retaining, preserving, retrieving and reproducing the electronic records);

(3) The electronic records are readily convertible into legible and readable paper copy as may be needed to satisfy reporting and disclosure requirements or any other obligation under Title I of ERISA;

(4) The electronic recordkeeping system is not subject, in whole or in part, to any agreement or restriction that would, directly or indirectly, compromise or limit a person's ability to comply with any reporting and disclosure requirement or any other obligation under Title I of ERISA; and

(5) Adequate records management practices are established and implemented (for example, following procedures for labeling of electronically maintained or retained records, providing a secure storage environment, creating back-up electronic copies and selecting an off-site storage location, observing a quality assurance program evidenced by regular evaluations of the electronic recordkeeping system including periodic checks of electronically maintained or retained records, and retaining paper copies of records that cannot be clearly, accurately, or completely transferred to an electronic recordkeeping system).

DRAFT

The Plan's electronically maintained records will exhibit a high degree of legibility and readability when displayed on a video display terminal or other method of electronic transmission and when reproduced in paper form. "Legibility" means the observer will be able to identify all letters and numerals positively and quickly to the exclusion of all other letters or numerals. "Readability" means that the observer will be able to recognize a group of letters or numerals as words or complete numbers.

Paper reports, records, and documents may be disposed of at any time after they are transferred to an electronic recordkeeping system that complies with the requirements stated in this Policy, except such original reports, records, or documents that would not constitute duplicate or substitute reports, records, or documents under the terms of the Plan or applicable federal or state laws when stored and accessed using electronic media.

ERISA Section 107 Record Retention & Maintenance

Pursuant to Section 107 of ERISA, the Plan will maintain a copy of the following reports, records, and documents, in a manner which provides in sufficient detail the necessary basic information and data, for a period of not less than six (6) years from the date the report, record, or document was filed:

- The annual report (Form 5500) filed for any Plan Year;
- The Plan funding notice for any Plan Year, if applicable;
- Any periodic actuarial report (including any sensitivity testing) received by the Plan for any Plan Year which has been in the Plan's possession for at least 30 days, if applicable;

DRAFT

- Any quarterly, semi-annual, or annual financial report prepared for the Plan by any Plan investment manager or advisor or other fiduciary which has been in the Plan's possession for at least 30 days;
- Audited financial statements of the Plan for any Plan Year; and
- Collective bargaining agreements and any changes thereto.

The reports, records, and documents which will be maintained include, but are not limited to, vouchers, worksheets, receipts, applicable resolutions, and any supporting information and documentation that would permit the Plan Administrator to verify, explain, and clarify Plan records to the DOL, and allow the DOL to check for accuracy and completeness. The Plan will keep such records available for examination by Participants to the extent required under ERISA.

ERISA Section 209 Record Retention & Maintenance

Pursuant to Section 209 of ERISA, to the extent applicable, the Plan will maintain records with respect to each Participant sufficient to determine the benefits due or which may become due to such Participants. The Plan will maintain such records in a manner that facilitates the production of reports by the Plan Administrator should any Participant (1) request such report in accordance with the regulations prescribed under Section 209 of ERISA, (2) terminate his or her service, or (3) have a one-year break in service. The following reports, records, and documents that will be maintained in this manner include, but are not limited to:

- Date of hire, rehire or termination;
- Participant eligibility date;
- Participant hours of service;
- Participant name, address, telephone number, and any other such contact information;

- Participant compensation;
- Contribution election forms;
- Designated beneficiary; and
- Records of any distributions requested by Participants.

Consistent with Proposed DOL Regulation 2530.209-2(d), the Plan will maintain reports, records, and documents of the type described in Section 209 of ERISA indefinitely, or for as long as a possibility exists that they might be relevant to a determination of the benefit entitlements of a Participant or Beneficiary, but not for a period of less than six (6) years.

Employer Reporting Record Maintenance

Each employer who is a participating employer will furnish written reports to the Trustees on a regular basis. A "participating employer" is any employer required to make contributions to the Plan for any reporting period with respect to such employer's employees, whether measured in service time or in output.

The reports will cover a reporting period of one (1) month. A reporting period of less than one (1) month of a year may be established by agreement, and different reporting periods may be established for different employers or different classes of employers participating in the Plan. A report will be furnished to the Trustees (or the Plan Administrator) no later than fifteen (15) days after the end of the reporting period to which it relates. Reports will contain all information that relates to service for, or other employment relationship with, the employer during the covered reporting period that is relevant to a determination of eligibility and benefit entitlements of:

DRAFT

(a) any of the employer's employees who has met the Plan's requirements for eligibility to participate in the Plan (including any requirement regarding service in a job classification covered by the Plan), whether or not such employee performs service in a job classification covered under the Plan during the reporting period; and

(b) any of the employer's employees who performs service in a job classification covered under the Plan during the reporting period, whether or not such employee has met the Plan's requirements for eligibility to participate during such reporting period.

The Trustees will make reasonable efforts to obtain complete and accurate information where a participating employer fails to furnish a report to the Trustees or the Trustees have reason to believe that the information furnished by such an employer is inaccurate. The Trustees may prescribe in writing rules concerning the format of reports, the manner of reporting, and reportable information. The Plan will maintain reports, records, and documents associated with or furnished by participating employers in a manner consistent with other reports, records, and documents described in this Policy.

DRAFT

The Trustees may delegate the responsibilities under this Policy to the Plan Administrator to the extent permitted under ERISA. This Policy is subject to the provisions of ERISA, the Health Insurance Portability and Accountability Act of 1996, the Consolidated Omnibus Budget Reconciliation Act of 1985, the Patient Protection and Affordable Care Act, and other applicable federal law and state law to the extent not preempted by federal law. This Policy is subject to the terms of the Plan and in a conflict the terms of the Plan shall govern. This Policy may be changed at any time by the Trustees.

Express Scripts Inc.
1 Express Way Saint Louis 63121-1824 MO

118088 R00007004483 800-332-5455

CHECK NO. 7389536

OUR REFERENCE #	YOUR INVOICE #	INVOICE DATE	DESCRIPTION	INVOICE AMOUNT	DISCOUNT TAKEN	NET CHECK AMOUNT
	R00007004483	03.25.20	REBATE 12-01-2019-12-31-2019_	15874.51	0.00	15874.51
				15874.51	0.00	15874.51

RECEIVED
APR 06 2020
AA, LLC

EPSFNCKU02 (09/04)

WARNING: Original document has an artificial watermark on reverse side, microline printing on border, and a void pantograph. Please endorse check on back.

Express Scripts
St Louis MO 63121

PNC Bank, N.A. 070 56-389/412

CHECK NO. 7389536

DATE 03.25.20

AMOUNT $ *******15,874.51

PAY FIFTEEN THOUSAND EIGHT HUNDRED SEVENTY FOUR DOLLARS AND 51 CENTS ONLY

TO THE ORDER OF
CARPENTERS LOCAL 491 H&W FUND
ATTN: MARK LYNNE
911 RIDGEBROOK ROAD
SPARKS MD US 21152

AUTHORIZED SIGNATURE

30

⑈07389536⑈ ⑆041203895⑆ 4116472067⑈

Express Scripts Inc.
1 Express Way   Saint Louis   63121-1824   MO

118088   R00007004483   **CHECK NO.**
800-332-5455   7396104

OUR REFERENCE #	*YOUR INVOICE #*	*INVOICE DATE*	*DESCRIPTION*	*INVOICE AMOUNT*	*DISCOUNT TAKEN*	*NET CHECK AMOUNT*
	R00007004483	05.01.20	REBATE 01-01-2020-01-31-2020_	10628.32	0.00	10628.32
				10628.32	0.00	10628.32

MAY 12 2020
AA LLC

EPSFNCKU02 (09/04)

WARNING: Original document has an artificial watermark on reverse side, microline printing on border, and a void pantograph. Please endorse check on back.

Express Scripts
St Louis MO 63121

PNC Bank, N.A. 070   56-389/412

CHECK NO. 7396104

DATE 05.04.20   **AMOUNT** $ *******10,628.32

PAY TEN THOUSAND SIX HUNDRED TWENTY EIGHT DOLLARS AND 32 CENTS ONLY

TO THE ORDER OF
CARPENTERS LOCAL 491 H&W FUND
ATTN: MARK LYNNE
911 RIDGEBROOK ROAD
SPARKS   MD   US   21152

Benjamin F. Alestrand
AUTHORIZED SIGNATURE

THIRTEENTH AMENDMENT

TO THE

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

Pursuant to the Powers of Amendment reserved under Section 15.1 of Article XV of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan"), effective as of January 1, 2014, said Plan shall be and is hereby amended by the Trustees of the Carpenters Local No. 491 Health and Welfare Plan (the "Trustees"), effective April 1, 2020, except such earlier date as required by law or as otherwise provided, as follows:

FIRST CHANGE

Section 3.7 shall be deleted in its entirety, and the following language is substituted in lieu thereof.

"**3.7 Self-Contributions.** An active Employee who fails to work the required number of hours to maintain his/her eligibility may continue his/her coverage for all benefits, except Weekly Disability, by making a self-contribution for the difference between the number of hours worked (and for which an employer contribution was payable) and the required hours. In order to be eligible to make a self-payment, an Employee must be eligible in the previous coverage quarter and must work at least 100 hours for the current work quarter.

If an Employee worked less than 175 hours in the work quarter, he/she can supplement his/her hours up to 175 hours by multiplying the current hourly health and welfare contribution rate times the hours that the Employee is short.

If the Employee was eligible in the previous quarter as a result of hours worked, and if he worked greater than 175 hours in that work quarter, the Employee can supplement his/her hours up to 250 hours by multiplying the current hourly health and welfare contribution rate times the hours that the Employee is short.

If the Employee was eligible in the previous quarter as a result of making a COBRA payment, and if he worked greater than 175 hours in that work quarter, the employer can make a self-payment in the following amount: the COBRA rate less an amount equal to the current hourly health and welfare contribution rate times the hours that the employer worked.

In all cases a minimum payment of $25 per quarter must be made by the Employee.

Provided the Employee works at least 175 hours in each work quarter, there is no maximum period of time during which the Employee may make self-payments. If the Employee is working between 100 and 175 hours and making self-payments, he may do so for a maximum of three consecutive quarters.

The employer must make payment under the self-payment rules within 30 days after the date of the mailing of the quarterly status report by the Administrator.

The self-payment quarters are included as part of the maximum period (18 months, 29 months or 36 months as the case may be) when considering COBRA. The amount of such self-contribution will be based on the current hourly contribution rate in effect, multiplied by the difference in hours worked and three hundred, limited to a maximum self-payment of $450 per quarter for the first two quarters and $550 per quarter for the third and fourth quarters.

Employees whose benefits are scheduled to be terminated due to failure to work the required number of hours and who are not eligible to make a self-contribution under the above provision, may still be eligible to make a self-contribution to maintain their medical benefits in effect under the provisions of COBRA.

Beginning January 1, 2017, the Employee can supplement his/her hours under this Section if he or she worked 175 hours or more in one calendar quarter, 350 hours or more in two calendar quarters, 525 hours or more in three calendar quarters, or 700 hours or more in four calendar quarters. If the Employee is not eligible to make a self-contribution under this provision, he or she may still be eligible to make a self-contribution to maintain medical benefits in effect under the provisions of COBRA."

SECOND CHANGE

Section 3.8 shall be deleted in its entirety, and the following language is substituted in lieu thereof.

"**3.8 Retired Participants – Self Payment Provision**. All retirees who retired either under a normal retirement or disability retirement as defined under the Carpenters Local No. 491 Pension Plan shall be entitled to make unlimited self-payments under the terms of the Plan. Such self-payment is for purposes of providing basic health care (supplementing Medicare once the retiree, or Dependent, is Medicare eligible), vision, and dental coverage for retirees and eligible Dependents. The Trustees have the right to change or eliminate this provision in the future to the extent they deem appropriate.

Retired participants and spouses over the age of 65 and disabled participants receiving an award from Social Security are entitled to Medicare, a broad federal program of health benefits which includes Hospital Insurance (Part A) and Voluntary Medical Insurance (Part B).

An Employee must enroll and maintain enrollment in the Hospital and voluntary medical insurance program of Medicare. Enrollment should be at the earliest opportunity available, since the Employee will be considered to be insured under Part A (Hospitalization) and Part B (Voluntary Medical) of Medicare whether or not the Employee has registered for Part A or enrolled for Part B.

In order for the Plan to avoid payment of benefits in a total amount greater than expenses incurred, benefits will first be paid under Medicare, and if there are any expenses remaining unpaid, these expenses will be paid up to the maximum amounts payable under the Plan."

THIRD CHANGE

Section 4.5 shall be deleted in its entirety, and the following language is substituted in lieu thereof.

4.5 Vacation Benefits. An Employee will become eligible for Vacation benefits as soon as any payments are made to the Plan on his/her behalf. If he/she is working under the Show Site Agreement between the Trade Show Contractors Association of Washington, D.C. and Vicinity and the Mid-Atlantic Regional Council of Carpenters, United Brotherhood of Carpenters and Joiners of America, a specified amount per hour will be deducted from his/her paycheck and paid to the Plan. The amount deducted per hour is set forth in the employer's Collective Bargaining Agreement. All hourly deduction rates are subject to change when new Collective Bargaining Agreements are negotiated in the future. This money is deducted from an Employee's paycheck on an "after-tax" basis. Income and Social Security taxes are withheld from an Employee's gross wages before the Vacation plan deduction is made.

Money is collected by the Plan and Vacation payments are made based on the money collected for a "Distribution Year." A Distribution Year runs from October 1 through the following September 30. At the end of each Distribution Year, the Plan adds up how much money was collected for each Employee. The Trustees of the Plan then determine how much earnings, if any, an Employee receives on the money. The amount of earnings is based on how much the Plan is able to earn by investing during the year.

During the first week of December, the money collected during the Distribution Year ending on the prior September 30, plus earnings (if applicable), will be distributed to an Employee by mail. The money paid in is not taxable when it is paid out, but the earnings paid by the Plan are taxable.

Each Employee must keep the Administrator advised of their current mailing address.

If an Employee who is entitled to receive a Vacation check dies before it is paid to him, the Vacation check will be paid to the Employee's Beneficiary for death benefits as named in the records of the Plan. That Beneficiary designation can be changed at any time.

Limitations:

Failure to receive Vacation payment: If for any reason an Employee does not receive his/her Vacation payment for any Distribution Year, he/she will only remain entitled to receive that payment for five (5) years. The amount of the payment will not earn any additional earnings after the Distribution Year to which it relates. If, after five (5) years from that Distribution Year, that Employee does not claim his/her Vacation payment or the Administrator cannot locate the Employee to send his/her payment, he/she will forfeit the payment.

Effective April 1, 2020, unless expressly renewed or modified by the Trustees in writing, exclusively for the calendar year of 2020, the money collected during the Distribution Year ending on September 30, 2019, plus earnings (if applicable), will be distributed to the Employee by mail, and shall be evenly divided between two separate payments during the 2020 calendar year. The first payment shall be issued during the first week of April 2020, and the second payment shall be issued during the first week of December 2020. The money paid in this 2020 calendar year is not taxable when it is paid out, but the earnings paid by the Plan are taxable. All other terms of this Section 4.5 remain unchanged and in full force and effect."

FOURTH CHANGE

Section 6.3 shall be deleted in its entirety, and the following language is substituted in lieu thereof.

6.3 Patient Protections. Pursuant to the PPACA, the Plan provides certain patient protections. Employees have the right to designate any primary care provider who is available to accept Employees or their family members. For help locating a primary care provider, visit www.MyIBXTPAbenefits.com or contact Independence Administrators at (833) 242-3330 or by U.S. mail to PO Box 21974, Eagan, MN 55121 (Payor ID 54763).

Further, Employees do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of health care professionals who specialize in obstetrics or gynecology, visit www.MyIBXTPAbenefits.com, or contact Independence Administrators at (833) 242-3330 or by U.S. mail to PO Box 21974, Eagan, MN 55121 (Payor ID 54763).

FIFTH CHANGE

Section 6.5 subsection (q) shall be deleted in its entirety, and the following language is substituted in lieu thereof.

"(q) **Maternity Benefit:** provided to the eligible Dependent spouse of an eligible active or retired Employee as well as to the active or retired Employee; unless otherwise provided by law, Dependent children are not eligible for maternity benefits outside of those prenatal services that are considered preventative services under the PPACA, all Hospital charges for room and board and miscellaneous services are covered the same as for any other illness, the fee charged by the Doctor for any obstetrical procedures is reimbursed up to the PPO fee maximum, services of a licensed midwife are paid, limited to the PPO fee maximum, the Plan does not offer this coverage to the child of the Dependent child or the spouse of the Dependent child,

Pursuant to the NMHPA, the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods, the attending provider, after consulting with the mother, may discharge the mother or newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section;"

SIXTH CHANGE

Article VII shall be deleted in its entirety, and the following language is substituted in lieu thereof.

"ARTICLE VII
PREFERRED PROVIDER ORGANIZATION

The Plan retains the services of a "Preferred Provider Organization" (PPO). A PPO is a group of select Doctors, specialists, Hospitals, and other treatment centers which have agreed to provide their services to eligible Employees for a discount. A PPO can be used for routine or emergency medical problems. It is not mandatory, so an Employee does not need to change his/her Doctor or the Hospital used, even if the Doctor or Hospital does not participate in the PPO program. However, if an Employee uses the PPO, both the Employee and the Plan will save money, as explained below.

The PPO has special arrangements with health care providers, such as Doctors and Hospitals, to substantially discount their normal fees. When PPO providers are used the Plan will not reimburse such providers for billed charges which exceed the negotiated PPO fee for such service.

Directories of participating PPO Doctors and Hospitals are available online through the Independence Administrator's website, www.MyIBXTPAbenefits.com, or by contacting Independence Administrators at (833) 242-3330 With limited exceptions discussed elsewhere in this Plan, the Plan does not cover services performed by persons other than Doctors. Simply because a provider is listed in the PPO directory does not mean they are covered by the Plan.

An Employee's identification card verifies participation in the PPO. The Hospital or Doctor will submit a claim directly to the PPO which will discount the bill and forward it to the Administrator for payment.

An Employee should let his/her current Doctor know that the Plan is participating in the PPO."

SEVENTH CHANGE

Section 8.1 shall be deleted in its entirety, and the following language is substituted in lieu thereof.

8.1 Eligibility. If an Employee is eligible for full coverage, he/she will also be eligible for vision, dental and prescription drug benefits. Notwithstanding the foregoing, retired Participants age 65 and over are not eligible for prescription drug benefits under the Plan. If an Employee is eligible for Partial coverage then the Employee will not be eligible for vision, dental and prescription drug benefits.

EIGHTH CHANGE

Section 8.2 shall be deleted in its entirety, and the following language is substituted in lieu thereof.

8.2 Prescription Drug Benefit. The prescription claims are administered by a Pharmacy Benefit Manager (PBM) chosen by the Plan Trustees. Eligible Employees and Dependents will automatically receive a prescription ID card which will entitle them to obtain drugs at participating pharmacies.

When the drugs are received, generally payment from the Employee will only consist of a co-payment amount (see the Summary Schedule of Benefits).

(a) Co-payment Required: An Employee will be required to pay a co-payment amount per prescription filled.

(b) What is Covered: Drugs prescribed by a Doctor which are required by law to be sold only by prescription or a compounded prescription if at least one of the ingredients is a prescription requiring drug.

As a cost-saving measure, the Board of Trustees has adopted a generic drug policy. Generic drugs are pharmaceutical equivalents to brand name drugs. They are approved by the Federal Food and Drug Administration and are considered to contain the same active ingredients and are identical in strength or concentration, dosage form, and type of administration, as brand name drugs. They may differ in characteristics such as color, shape, packaging, preservations, expiration time, and within certain limits, labeling.

Under the generic drug policy an Employee should note the following:

(i) If there is no generic equivalent, then the pharmacy will dispense the brand name drug and be reimbursed by the Plan.

(ii) If an Employee insists upon a brand name drug and there is a generic equivalent, then the Employee must pay the difference in price in addition to the co-payment amount.

As an additional cost savings measure, the Board of Trustees has adopted a Step Therapy program whereby Participants benefit from using generic medications or lower cost brand alternatives ("Front Line Therapies") as opposed to brand name drugs ("Back-up Drugs"). This program is designed for Participants who take prescription drugs on a regular basis to treat ongoing medical conditions. Under this program, the first time a Participant submits a prescription for a Back-up Drug the pharmacist will notify the Participant of the Plan's use of the Step Therapy program and the Participant will be required to either proceed in having the Front Line Therapy filled or paying full price for the Back-up Drug. The use of a Back-up Drug will be covered by the Plan to the extent the Participant has (i) already tried the Front Line Therapy covered in the Step Therapy program, (ii) the Participant cannot take the Front Line Therapy, or (iii) the Participant's Doctor decides, for medical reasons, that a Back-up Drug is needed.

Similarly, as an additional cost savings measure, the Board of Trustees has adopted a $0 Co-pay Program whereby Participants will be entitled to relief, on a one-time only basis, from the co-pay associated with filling a prescription, to the extent the Participant chooses a generic prescription as opposed to a brand name prescription. The waived co-pay will only apply to specific targeted prescriptions as the Plan shall determine from time to time and will be restricted to a six (6) month supply.

(c) Covered Injectable Prescriptions: Generally injectable drugs are not covered. The following are covered by the Plan, however, with some requiring prior approval from the PBM:

(i) No Prior Approval
- Epipen
- Imitrex
- Insulin

(ii) Prior Approval Required
- Interferon
- Depo-Provera
- Heparin
- Botox (for treatment of Cerebral Palsy only)
- Lovenox

If an Employee is prescribed a drug which requires prior approval, the Employee must contact the Administrator immediately.

(d) What Is Not Covered:

(i) any non-legend drug, except insulin;

(ii) vitamins, minerals, dietary supplements, cosmetics or beauty aids;

(iii) any medication which is to be taken by or administered while an Employee or his/her Dependent is confined in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution;

(iv) more than a 34-day supply unless specifically authorized by a Doctor;

(v) any drug labeled "Caution - Limited by Federal Law to Investigational Use" or experimental drugs whether or not a charge is made to the patient;

(vi) smoking cessation drugs; or

(vii) unless otherwise required by law, contraceptive drugs or devices, with the following exception: oral contraceptives may be covered if a Doctor prescribes them for medical (not contraceptive) purposes and is able to document their medical necessity. Such contraceptives will be covered at 50% up to a maximum Plan payment of $15 per 34-day supply, unless otherwise required by law. Should an Employee or an eligible Dependent patronize a non-participating pharmacy they can be reimbursed by the pharmacy benefit manager.

(e) In Order To Be Reimbursed Directly: An Employee must:

(i) Obtain reimbursement drug forms from the Administrator.

(ii) Ensure that the forms are properly completed by the pharmacy; this includes:

- Name of the drug and quantity dispensed
- Date dispensed
- Name and address of the pharmacy
- Authorizing Doctor's name
- Patient's name
- Eligible Employee's signature of acceptance
- Employee's name, social security number, and group number

- Following completion, the form should then be submitted to the PBM together with the paid receipt.
- In order to get a prescription card an Employee needs an enrollment form on file at the Administrator.

(f) As an additional cost savings measure, the Board of Trustees has adopted a Prior Authorization Program under which the Plan will monitor certain prescription drugs to ensure that covered drugs are used for medical problems rather than for other purposes (i.e. cosmetic, etc.). Through the use of the Prior Authorization Program, Participants will be notified by the pharmacist if a specific prescription requires prior authorization. If prior authorization is required, the Participant can (i) ask his/her Doctor to contact the PBM to explain the use of the prescription, (ii) ask his/her Doctor whether another covered medication could be used for this purpose, or (iii) simply pay the full price for the prescription at the pharmacy.

(g) As an additional cost savings measure, the Board of Trustees has adopted a mail order drug program for maintenance types of drugs, up to a 90-day supply for two co-payments. Prescriptions filled through non-mail order retail locations will be limited to a 30-day supply."

NINTH CHANGE

Article X shall be deleted in its entirety, and the following language is substituted in lieu thereof.

ARTICLE X
GENERAL LIMITATIONS AND EXCLUSIONS

The following charges are not covered under this Plan; therefore, the amount of benefits payable under the Plan is determined after these charges are deducted from covered expenses:

(a) charges incurred while not covered under this Plan;

(b) charges that would not have been made if coverage did not exist;

(c) charges that an Employee or their Dependents are not required to pay;

(d) charges for services or supplies which are furnished, paid or otherwise provided for by reason of the past or present service of any person in the armed forces unless otherwise required by law;

(e) charges for nursing or other services performed by a person who ordinarily resides in the patient's home or is a member of the Employee's family or the Employee's spouse's family;

(f) charges for services or supplies which are paid for or otherwise provided for under any laws of the government unless required by federal law;

(g) charges for services or supplies which are not medically necessary for treatment of an injury or illness or are not provided, recommended or prescribed by a legally-qualified surgeon or Doctor;

(h) charges to the extent that they are not usual, customary and reasonable;

(i) charges for an injury or illness covered by workers' compensation laws;

(j) charges for the purchase or fitting of a hearing aid;

(k) charges for blood plasma or whole blood;

(l) charges by an intern of a Hospital;

(m) charges for transportation or travel except as otherwise covered under the Plan;

(n) medicines which may be purchased without a prescription or are not prescribed to treat an illness or injury;

(o) charges for custodial care;

(p) charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;

(q) charges for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;

(r) charges for dependent child maternity benefits outside of those prenatal services that are considered preventative services under the PPACA;

(s) charges for chiropractic care;

(t) charges incurred as a result of war, declared or undeclared, including armed aggression;

(u) charges incurred as the result of a commission of a crime (If a copy of a police report is required, this will be obtained at the expense of the covered individual);

(v) cosmetic procedures (except as otherwise required by law) and associated expenses;

(w) the services of private duty registered and licensed practical nurses, unless medically necessary;

(x) physical or psychiatric examinations or psychological testing for purposes of obtaining or maintaining employment, licensure, legal proceeding, registration or insurance, or conducted for purposes of medical research, physical examinations for camp, school, sport, or other similar activities;

(y) any elective surgical procedure including all associated expenses, intended primarily for treatment of morbid obesity;

(z) any surgical procedure, including all associated health services, for the reversal of voluntary sterilization;

(aa) speech therapy and evaluation, diagnosis and treatment of educable children diagnosed as having special learning disabilities;

(bb) any loss or charges for sexual transformation, sexual enhancement or any treatment relative to sexual dysfunction, unless medically necessary;

(cc) artificial insemination;

(dd) in-vitro fertilization and embryo transplants;

(ee) charges for services or supplies for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ) and any related disorders or procedures regardless of medical necessity;

(ff) charges incurred or resulting from an injury caused by a third party in which the eligible Employee or covered Dependent has recovered by suit, settlement or otherwise;

(gg) dental X-rays, except in the case of an accidental Bodily Injury;

(hh) examinations that are not recommended or approved by a legally qualified Doctor or surgeon;

(ii) eye examinations, unless otherwise provided in the Plan;

(jj) dental disorders, except as otherwise provided in the Plan;

(kk) eye refraction, eyeglasses or their fitting, except as provided under the Vision Benefits section of the Plan;

(ll) hearing aids or their fittings;

(mm) drugs and medicines, except as otherwise provided herein; or

(nn) charges incurred due to psychiatric or personality disorders, drug abuse or alcohol abuse, except as otherwise required by the Mental Health Parity and Addiction Equity Act.

The term "custodial care" means services and supplies, including room and board and other institutional services, primarily to assist a person in the activities of daily living, whether or not he/she is disabled. However, room and board and skilled nursing care for a person in a Hospital are not considered custodial care if they must be combined with therapeutic services needed to improve his/her medical condition.

The Plan only covers treatments, services or supplies that are necessary, reasonable and recommended or approved by the attending Doctor.

TENTH CHANGE

Section 14.5 (a) shall be deleted in its entirety, and the following language is substituted in lieu thereof.

14.5 Claims and Appeals Procedures.

(a) Proof of Loss – Claims must be filed with the Claims Administrator no later than two (2) years from the date that the treatment or service on which the claim is based is provided. Specifically, a completed claim form, corresponding itemized bills and other information necessary to process the claim, which represent proof of loss related to a Covered Medical Expenses incurred by a Participant must be received by the Claims Administrator or PPO no later than two (2) years from the date the service was rendered or otherwise provided.

The Plan reserves the right, at its discretion, to accept or to require verification of any alleged fact or assertion pertaining to any claim.

In the event of Plan termination, all claims incurred by an Employee must be received by the Claims Administrator within ninety (90) days of the date of termination of the Plan.

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If an employee or an employee's spouse, dependent or beneficiary (hereinafter referred to as a "Claimant") is denied any benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable.

If the Plan fails to adhere to the internal claims and appeals process required herein, a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under paragraph (e) of this section and is entitled to pursue any available remedies under

ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

ELEVENTH CHANGE

All references in the Plan to "Optical" shall be replaced with the word "Vision."

TWELFTH CHANGE

All references in the Plan to "data card" shall be replaced with "enrollment form."

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Trustees have executed this Thirteenth Amendment to the Plan this _____ day of _____, 2020.

WITNESS:

_____ _____
KEN BISCH

_____ _____
SANDRA FORSTNER

_____ _____
D. MICHAEL GOODWIN

_____ _____
BILL SPROULE

_____ _____
ROBERT TARBY

_____ _____
TODD WEITZMAN

NAME: **SS#:**
REGARDING:

Carpenters' Local No. 491 Health and Welfare Plan

LOCAL: 491
STATUS: Full Time

ISSUE: Eligibility – Extension of Dependent Coverage Beyond Age 26 #E20/112-3135

FUND RULE:
"**Eligibility**

Your eligible dependents are, except as otherwise provided herein:

- Your children (including "adult children," legally adopted children, foster children and stepchildren) under the age of 26 […]" (Carpenters' Local No. 491 Health and Welfare Plan SPD, Page 6)

SUMMARY: Appeal Received: June 10, 2020

The **participant's daughter (DOB: 4-27-1994)** is appealing to be allowed an extension of dependent coverage related to a postponed dental procedure.

Fund records indicate the participant's daughter lost eligibility for dependent coverage on April 27, 2020, when she turned age 26.

The participant's daughter states in summary that she is a nurse and was scheduled to have her wisdom teeth extracted on April 6, 2020, but she became infected with COVID-19 and tested positive on April 4, 2020. Because of this, she was unable to have the dental procedure done. The participant's daughter further states that she rescheduled the procedure for the third week of April, however, she was not yet cleared by her doctor, and rescheduled her procedure for May 6, 2020. The participant's daughter states that members of her household also contracted COVID-19 which forced her to reschedule her procedure again for June 15, 2020. Lastly, the participant's daughter states that COVID-19 forced her to delay care for her personal health and she cannot afford to pay for this dental procedure out-of-pocket. Included with the appeal were letters from her dentist's office (HarborView Surgical Arts), her doctor (John Lee, MD), and her COVID-19 test results.

Note: The cost of COBRA coverage is $310.00 per month. To date, the participant's daughter has not elected COBRA coverage.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

CARPENTERS LOCAL NO. 491 VACATION BENEFIT
STATEMENT OF CHANGES IN FUND BALANCE - CASH BASIS
FOR THE THREE MONTHS ENDED MARCH 31, 2020

	January	February	March	Year To Date
Additions				
Employer Contributions	$ 52,256.59	$ 71,137.93	$ 67,338.33	$ 190,732.85
Interest Income	23.95	35.93	39.29	99.17
Total Additions	52,280.54	71,173.86	67,377.62	190,832.02
Deductions				
Audit Fees	-	-	-	-
Benefits Paid	-	-	-	-
Interest Paid	-	-	-	-
Legal Fees	-	-	-	-
Office Expenses	-	-	-	-
Postage	-	-	-	-
Printing	-	-	-	-
Bank Service Charges	-	-	-	-
Total Deductions	-	-	-	-
Net Increase (Decrease)	$ 52,280.54	$ 71,173.86	$ 67,377.62	$ 190,832.02
Fund Balance - December 31, 2019				244,400.89
Fund Balance - March 31, 2020				$ 435,232.91

Statement of Fund Balance - Cost Basis

Cash - Bank of America - Vacation Payment	$ 427,383.11
Cash - Madison Bank - Ultimate Checking	7,849.80
	$ 435,232.91