Carpenters' Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, Maryland 21152-9451
Toll Free Telephone (888) 494-4443
www.associated-admin.com

ANNOUNCEMENT TO PARTICIPANTS

CARPENTERS LOCAL NO. 491

HEALTH AND WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATION

The Trustees of the Carpenters Local No. 491 Health and Welfare Plan, on behalf of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") announce that the Plan has been amended, effective as of January 1, 2020.

The purpose of the amendment is to increase the Optical benefits available to participants from a maximum of $150 per eligible Employee and eligible Dependent per year to a maximum of $250 per eligible Employee and eligible Dependent per year. The amendment also increases the Dental benefits available to participants from a maximum of $1,000 per eligible Employee and eligible Dependent per year to a maximum of $1,500 per eligible Employee and eligible Dependent per year.

This is a brief announcement to employees. In the case of a conflict, the terms of the Plan govern the terms of this announcement and the Summary Plan Description. If you have any questions on the announcement or the Plan, please contact the Plan Administrator.

****** Please keep this Summary of Material Modifications with your Summary Plan Description for the Carpenters Local No. 491 Health and Welfare Plan ******

Trustees of the
Carpenters Local No. 491
Health and Welfare Plan
January 2020

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ANNOUNCEMENT TO PARTICIPANTS

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATIONS

The Trustees of the Carpenters Local No. 491 Health and Welfare Plan on behalf of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") are announcing that the Plan has been amended. The Plan has been amended as follows:

Retroactive to March 18, 2020, the Covered Medical Expenses provision has been amended in accordance with the Families First Coronavirus Response Act ("Response Act") to cover in vitro diagnostic products for the detection of the Coronavirus or diagnosis of the virus that causes COVID-19 that are approved, cleared, and authorized by the U.S. Food and Drug Administration (FDA).

- Retroactive to March 18, 2020, the Covered Medical Expenses provision has been further amended to cover items and services furnished during a healthcare provider office visits (including telehealth visits), urgent care visits, and emergency room visits that result in an order for an administration of the in vitro diagnostic products related to the detection of the Coronavirus or diagnosis of the virus that causes COVID-19, but only to the extent that those items and services provided during the visits relate to the furnishing of the FDA approved, cleared, and authorized diagnostic product(s) or evaluation of the individual if he or she needs such a product.
- Retroactive to March 18, 2020, the Covered Medical Expenses provision has been further amended to state the products and services mentioned above are to be provided without prior authorization or any other medical management requirements

Retroactive to March 18, 2020, in accordance with the Response Act, the Plan Deductible and Coinsurance provision has been amended to waive all Plan Deductible and Plan Coinsurance charges incurred for products and services for the FDA approved, cleared, and authorized diagnostic products related to the detection and diagnosis of the virus that causes COVID-19.

- Effective April 1, 2020, the Plan Deductible and Coinsurance provision has been further amended to waive Plan Deductible and Plan Coinsurance

amounts for any and all services covered by the Plan through December 31, 2020, unless expressly renewed or modified by the Trustees in writing.

Retroactive to March 18, 2020, in accordance with the Response Act, Article VI Health Care Benefits has been amended to waive all co-payment amounts for all charges incurred for products and services for the detection of the Coronavirus or diagnosis of the virus that causes COVID-19 that are approved, cleared, and authorized by the FDA.

- Effective April 1, 2020, Article VI Health Care Benefits has been further amended to waive all co-payment for any and all services covered by the Plan through June 30, 2020, unless expressly renewed or modified by the Trustees in writing.

Effective April 1, 2020, the Initial and Continuing Eligibility for Active Employees provision was amended to provide that all active Employees will be automatically eligible for and continue to receive full or partial coverage under the Plan on the first day of the April 1, 2020, – June 30, 2020, Benefit Quarter, provided the Employee must have been working in covered employment for a participating employer in October 1, 2019, - December 31, 2019, Work Period and satisfied the minimum hours worked in the appropriate quarter(s) stated under Plan terms.

- The Initial and Continuing Eligibility for Active Employees provision was further amended to provide that all active Employees will automatically continue to receive full or partial coverage under the Plan in the July 1, 2020 – September 30, 2020, Benefit Quarter, if said Employee was eligible for full or partial coverage in the April 1, 2020, - June 30, 2020, Benefit Quarter upon the terms stated above.

Effective April 1, 2020, the Vacation Benefits provision was amended to provide that for the 2020 calendar year, the money collected during the Distribution Year for vacation benefits, plus earnings (if applicable), will be evenly divided between two separate payments sent via the U.S. mail. The first payment will be issued during the month of April 2020, and the second payment will be issued during the first week of December 2020. The Vacation Benefits money paid during the 2020 calendar year will not be taxable when paid out, but the earnings paid by the Plan are taxable.

This is a brief announcement to employees. The Plan Administrator will be updating the Summary Plan Description in the near future. In the case of a conflict, the terms of the Plan govern the terms of this announcement and the Summary Plan Description. If you have any questions on the announcement or the Plan, please contact the Plan Administrator.

Trustees of the
Carpenters Local No. 491 Health and Welfare Plan
March 2020

Carpenters Local No. 491 Health and Welfare Fund

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ANNOUNCEMENT TO PARTICIPANTS

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATIONS

The Trustees of the Carpenters Local No. 491 Health and Welfare Plan on behalf of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") are announcing that the Plan has been amended to make benefit changes that will be implemented October 1, 2020. The Plan has been amended as follows:

The Initial and Continuing Eligibility for Active Employees provision was amended to provide that active Employees will automatically continue to receive full coverage in the October 1, 2020, - December 31, 2020, Benefit Quarter if the Employee was eligible for full coverage in July 1, 2020, - September 30, 2020, Benefit Quarter, upon the terms and requirements of the provision, and an active Employee will automatically continue to receive partial coverage in the October 1, 2020, - December 31, 2020, Benefit Quarter, if said Employee was eligible for partial coverage in the July 1, 2020, - September 30, 2020, Benefit Quarter, upon the terms and requirements of the provision.

This was the only change made to the Initial and Continuing Eligibility for Active Employees provision.

This is a brief announcement to employees. The Plan Administrator will be updating the Summary Plan Description in the near future. In the case of a conflict, the terms of the Plan govern the terms of this announcement and the Summary Plan Description. If you have any questions on the announcement or the Plan, please contact the Plan Administrator.

Trustees of the
Carpenters Local No. 491 Health and Welfare Plan
September 2020

Carpenters Local No. 491 Health and Welfare Fund

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ANNOUNCEMENT TO PARTICIPANTS
CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN
SUMMARY OF MATERIAL MODIFICATIONS

The Trustees of the Carpenters Local No. 491 Health and Welfare Plan, on behalf of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") are announcing that the Plan has been amended to make benefit changes that will be implemented effective October 1, 2021. The Plan has been amended as follows:

Effective October 1, 2021, exclusively for the dates stipulated below, an active Employee will be eligible for and will receive full coverage or automatically continue to receive full coverage in the following Benefit Quarters if said Employee is credited with at least 150 hours (rather than 250 hours) of work in covered employment in the below listed work periods:

Work Period	Benefit Quarter
July 1, 2021 – September 30, 2021	January 1, 2022 – March 31, 2022
October 1, 2021 – December 31, 2021	April 1, 2022 – June 30, 2022

Effective October 1, 2021, exclusively for the dates stipulated below, an active Employee will be eligible for and will receive partial coverage or automatically continue to receive partial coverage in the following Benefit Quarters if said Employee is credited with at least 100 hours (rather than 175 hours) of work in covered employment in the below listed work periods:

Work Period	Benefit Quarter
July 1, 2021 – September 30, 2021	January 1, 2022 – March 31, 2022
October 1, 2021 – December 31, 2021	April 1, 2022 – June 30, 2022

This is a brief announcement to employees. The Plan Administrator will be updating the Summary Plan Description in the near future. In the case of a conflict, the terms of the Plan govern the terms of this announcement and the Summary Plan Description. If you have any questions on the announcement or the Plan, please contact the Plan Administrator.

Trustees of the
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September 2021

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ANNOUNCEMENT TO PARTICIPANTS

CARPENTERS LOCAL NO. 491

HEALTH AND WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATION

The Trustees of the Carpenters Local No. 491 Health and Welfare Plan, on behalf of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") announce that the Plan has been impacted by the Consolidated Appropriations Act of 2021 (CAA), the key component of which is known as the No Surprises Act, effective as of January 1, 2022.

Among other changes to employee health plans, some of the CAA changes are intended to protect consumers from certain balance-bills for out-of-network medical services, to increase health plan transparency around medical costs and coverage, and new disclosure requirements. Under the No Surprises Act of the CAA, plan sponsors and providers are prohibited from billing participants for more than the in-network cost-sharing amount due under their plans in most cases of out-of-network surprise billing for emergency services, for services at in-network facilities, and for air ambulance services. The most notable exclusion from the revised billing requirements is for ground ambulance transport. Additionally, all amounts paid by a participant must count toward the participant's in-network annual deductible and in-network annual out-of-pocket maximum.

Essentially, the No Surprises Act provides that when you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. Balance billing, also known as surprise billing, is when you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

Out-of-network describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Under the No Surprises Act you are protected from balance billing for emergency services and certain services at an in-network hospital or ambulatory surgical center. If you have an emergency medical condition and get emergency services from an out-of-network provider at a facility, the most the provider or facility may bill you is your plan's in-network cost-sharing

amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount. The applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections for balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you could pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider of facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward you deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact the Plan Administrator.

This is a brief announcement to employees. In the case of a conflict, the terms of the Plan and the CAA (including the No Surprises Act) govern the terms of this announcement and the Summary Plan Description. If you have any questions on the announcement, the CAA, the No Surprises Act, or the Plan, please contact the Plan Administrator.

****** Please keep this Summary of Material Modifications with your Summary Plan Description for the Carpenters Local No. 491 Health and Welfare Plan ******

Trustees of the
Carpenters Local No. 491
Health and Welfare Plan
December 2021

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ANNOUNCEMENT TO PARTICIPANTS
CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN
SUMMARY OF MATERIAL MODIFICATIONS

The Trustees of the Carpenters Local No. 491 Health and Welfare Plan on behalf of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan") are announcing that the Plan has been amended to make benefit changes that were effective retroactive to January 15, 2022. The Plan has been amended as follows:

Effective retroactive to January 15, 2022, and throughout the national public health emergency of COVID-19, the Plan will cover up to 8 Food and Drug Administration ("FDA") approved at home COVID-test kits per covered member, per month up to $12.00 per test (Please note: if a test kit includes 2 tests, reimbursement will be limited to 4 test kits). You do not need prior authorization from a doctor or other healthcare provider to purchase the tests.

Here is how it works:

- Use your Express Scripts ID card at any network retail pharmacy
- Bring the COVID-19 test to the **pharmacy counter, not the regular checkout lane**.
- Check out at the pharmacy counter and show your Express Scripts ID card. Your at-home COVID-19 test should automatically ring up at no cost to you.
- If you were not able to purchase your at-home COVID-19 test(s) at the pharmacy counter, or happened to be charged, you can submit your receipt for reimbursement of up to $12.00 per test for reimbursement online through your Express Scripts account at www.express-scripts.com/covid-19/resource-center or to obtain a claim reimbursement form. Claim reimbursement forms can also be received by contacting the Fund Office at (888)494-4443

Please note that the Plan's reimbursement is limited to tests for personal use and not for employment-related testing or resale. The Express Scripts reimbursement form will require you to provide an attestation certifying that the test kits received were not for employment-related COVID-19 testing requirements and were used for personal use and not resale.

In addition, you can also order 4 free at home COVID-19 test kits per household online at COVIDTests.gov.

If you have any questions on the announcement or the Plan, please contact the Fund Office at (888) 494-4443.

Trustees of the
Carpenters Local No. 491 Health and Welfare Plan
September 2021