Carpenters' Local No. 491
Health and Welfare Plan
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SUMMARY OF MATERIAL MODIFICATIONS

This Insert is a Summary of Material Modifications (changes) to your Summary Plan Description ("SPD") booklet. If there is any discrepancy between the terms of the Plan or any amendments and this document, the provisions of the Plan, as amended, will control. Please keep this Insert with your booklet so you will have it when you need to refer to it.

July 2018

- **Effective January 1, 2018,** 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, effective January 1, 2018. The Plan has amended the Dental Benefit provision in the Plan.

  The Plan has contracted with CIGNA for discounts from dentists. Employees will get the best benefit if they use a dentist who participates in the CIGNA Dental Preferred Provider Organization (PPO) network. The allowed amount for each dental procedure will be based on a schedule determined by CIGNA. The Plan benefit will depend on the type of procedure. The benefit schedule is listed below. If Employees use an In-Network Provider, they will be responsible for the percentage of the allowed amount that the Plan does not pay. For instance, for a filling (Basic Restorative procedure) the Plan will pay 75% of the allowed amount and Employees will be responsible for the remaining 25%. If Employees use an Out-of-Network Provider, they will be responsible for the remaining percentage of the allowed amount for that procedure **plus** any difference between the allowed amount and what the provider charges.

  Employees may use the dentist of their choice, but as noted above, the benefit will be maximized if they use an In-Network Provider. The best way to see if a dentist participates in the CIGNA PPO network is to access the CIGNA website. The CIGNA website address is: www.cignadentalsa.com. Employees can also call CIGNA at 800-797-3381. The Dental Schedule below shows the benefit provided and how the benefit differs depending on whether Employees choose an In-Network Provider or an Out-of-Network Provider.

  The Dental Benefits Schedule has changed and employees no longer need to obtain a dental form from the Administrator. The Dental Schedule now states:

  For an In-Network Provider:

Diagnostic/Preventive -	Dental Benefits Paid at 100%
Basic Restorative -	Dental Benefits Paid at 75%
All Other Services -	Dental Benefits Paid at 40%

For an Out-of-Network Provider:

Diagnostic/Preventive -	Dental Benefits Paid at 80%
Basic Restorative -	Dental Benefits Paid at 60%
All Other Services -	Dental Benefits Paid at 30%

A partial list of services by category is included below:

DIAGNOSTIC AND PREVENTIVE SERVICES

- Oral Evaluations (periodic; comprehensive)
- Prophylaxis (cleanings)
- Topical fluoride applications
- General x-rays – bitewing limit once every six months
- Panorex or full mouth x-rays – limit one per calendar year
- Space maintainers
- Sealants

BASIC RESTORATIVE SERVICES

- Restorations/fillings (amalgams/composite resins)

ALL OTHER SERVICES

- Oral surgery (e.g., extractions; removal of impacted teeth)
- Periodontics (e.g., gingivectomies; root planing)
- Endodontics (e.g., root canals; apicoectomies)
- Dentures
- Bridges
- Crowns

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. You will be receiving dental identification cards in the mail within the next two weeks.

- **Effective October 1, 2016 –** The Plan has been amended as follows:

In order to become eligible for full Plan coverage during a coverage quarter (3 months), an employee must work in covered employment for a participating employer a minimum of 250 hours in the appropriate quarter, 450 hours in two calendar quarters, 700 hours in three calendar quarters, or 950 hours in four calendar quarters as follows:

250 Hours Worked During the Period	450 Hours Worked During the Period	700 Hours Worked During the Period	950 Hours Worked During the Period	Eligible Period
January 1 – March 31	October 1 – March 31	July 1 – March 31	April 1 – March 31	July 1 – September 30
April 1 – June 30	January 1 – June 30	October 1 – June 30	July 1 – June 30	October 1 – December 31
July 1 – September 30	April 1 – September 30	January 1 – September 30	October 1 – September 30	January 1 – March 31
October 1 – December 31	July 1 – December 31	April 1 – December 31	January 1 – December 31	April 1 – June 30

In order to become eligible for partial Plan coverage during a coverage quarter (3 months), an employee must work in covered employment for a participating employer a minimum of 175 hours in the appropriate quarter, or 350 hours in two calendar quarters as follows:

175 Hours Worked During the Period	350 Hours Worked During the Period	Eligible Period
January 1 – March 31	October 1 – March 31	July 1 – September 30
April 1 – June 30	January 1 – June 30	October 1 – December 31
July 1 – September 30	April 1 – September 30	January 1 – March 31
October 1 – December 31	July 1 – December 31	April 1 – June 30

Further, the Plan's Spendthrift provision has been amended to prevent any assignment of benefits to a doctor, hospital, or other person or institution from which an employee, dependent or beneficiary received medical, hospital or other services for which such benefits are payable. This was the only change made to the previous Spendthrift provision.

- **Effective January 1, 2016 –** The Plan has been amended to increase the deductible and out-of-pocket maximums for shop Employees as follows:

  Deductible (per calendar year, combined annual deductible on all medical, surgical, mental health and substance abuse disorder benefits)
  Per exhibitor Employee $250
  Per shop Employee $500
  Per family (where Employee works for an exhibitor).......................................$500
  Per family (where Employee works for a shop) $1,000

For Active Participants who Satisfy the Eligibility Requirements for Full Coverage and for Employees of Employers who are Covered by a Participation Agreement, the Coinsurance is as follows:

Coinsurance………..after deductible, Plan pays 80% up to a participant out-of-pocket maximum of $6,600 ($3,600 for medical and $3,000 for prescription) per individual per year where the Employee works for an exhibitor and a maximum of $6,850 ($3,850 for medical and $3,000 for prescription) per individual per year where the Employee works for a shop or $13,200 ($7,200 for medical and $6,000 for prescription) per family per year where the Employee works for an exhibitor and $13,700 ($7,700 for medical and $6,000 for prescription) where the Employee works for a shop, if applicable.

For Active Participants who Satisfy the Eligibility Requirements for Partial Coverage, the Coinsurance is as follows:

Coinsurance ………..after deductible, Plan pays 40% up to a participant out-of-pocket maximum of $6,600 ($3,600 for medical and $3,000 for prescription) per individual per year where the Employee works for an exhibitor and a maximum of $6,850 ($3,850 for medical and $3,000 for prescription) per individual per year where the Employee works for a shop or $13,200 ($7,200 for medical and $6,000 for prescription) per family per year where the Employee works for an exhibitor and $13,700 ($7,700 for medical and $6,000 for prescription) where the Employee works for a shop, if applicable.

- **Effective January 1, 2015 –** The Plan has amended its Prescription Drug Schedule to state as follows:

Prescription Drugs

- Paid in Full, after a $5.00 co-payment for generic drugs for a 30-day supply,
- $10.00 co-payment for generic drugs for a 90-day supply,
- 25% co-payment for brand drugs,
- Maximum of $75.00 for a 30 day supply,
- Maximum of $150.00 for a 90 day supply,
- 40% co-payment for compound drugs and non-formulary brand drugs,
- There is a mandatory mail order for maintenance drugs,
- Three prescription fills are allowed at a pharmacy and the fourth fill must be through mail order,
- Maintenance drugs through mail order are for a 3-month supply for the price of two co-payments.

Further, an eligible person must pay 20% coinsurance of all covered expenses after the deductible has been satisfied, up to a yearly maximum of $6,600 ($3,600 for medical and $3,000 for prescription). The family coinsurance amount is 20% of all covered expenses after the deductible has been satisfied, up to a yearly maximum of $13,200 ($7,200 for medical and $6,000 for prescription).

Finally, for non-preventive care doctor visits, eligible employees and dependents must pay a $25.00 co-payment for each doctor visit, with such co-payment applying towards the out-of-pocket maximum (coinsurance limits).

- **Effective December 1, 2014 –** The Plan has been amended to cover the use of a hospital facility and anesthesia where impacted wisdom teeth are removed. However, any dentists' fees relating to the removal of impacted wisdom teeth will apply towards the annual maximum for the dental benefit and based upon the dental fee schedule.

- **Effective January 1, 2013,** 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 by adding a provision on opting-out of health coverage. This provision provides:

OPTING-OUT OF HEALTH COVERAGE

If you and/or your dependents have other coverage and therefore do not need health coverage through the Plan, you may suspend coverage and still be able to resume this health coverage at a later date. If you and/or your dependents elect to opt-out, contributions will continue to be made to the Plan and will not be paid to you and are non-refundable.

You may elect to opt-out and suspend coverage for yourself and your dependents, for yourself only, or for your dependents only. Once you elect to opt out, you cannot re-enroll in the Plan for a minimum of six (6) months. To be eligible to opt-out and resume this coverage later, you and/or your dependents must be covered under another health plan, such as through your spouse's employer.

What You Need to Do to Opt-Out

To opt-out and suspend coverage until a later date, you must complete and return an *Opt-Out Form* to the Plan Office. If you elect to suspend coverage, coverage will be suspended as of the first day of the month following receipt of your completed form.

To Resume Coverage

You may resume coverage at any time after having suspended coverage for at least six (6) months. To resume coverage for yourself and/or your eligible dependents, you must:

1. File a written application with the Plan Office within sixty(60) days following the date the other coverage ends; and
2. Provide proof of continuous coverage (such as a Certificate of Creditable Coverage) from the other health plan from the date coverage under this Plan was suspended (if proof of continuous coverage is not provided, you and/or your dependents will not be eligible for coverage).

Coverage will resume as of the first day of the month after your application for coverage is approved, provided you otherwise meet the Plan's eligibility requirements.

- **Effective May 1, 2012,** 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") announced that the Plan has been amended.

  The Plan amended its definition of Collective Bargaining Agreement to mean the collective bargaining agreement between the Carpenters' Local No. 491 and participating employers in the jurisdiction of said Local, as in effect from time to time. It shall include, where appropriate, an agreement between the Plan and participating employers by way of a participation agreement.

  The Plan also amended its definition of Employee to mean any person whose wages are established by the Collective Bargaining Agreement or any other employee of an employer for whom contributions are made. For purposes of this Plan, the union shall be considered the employer as to any employees of the union. Additionally, all persons employed by a District Council who are assigned by the District Council to the union and are employees who previously were collectively bargaining employees. Anything herein to the contrary notwithstanding, coverage and eligibility for benefits of any Employee shall be subject in all respects to the terms and provisions of the Plan, or the applicable Policy.

  Further, the Plan added a new section called "Eligibility for Employees of Employers Who are Covered by a Participation Agreement." This section provides that employees of employers who contribute to the Collective Bargaining Agreement who are covered by a participation agreement shall be eligible for benefits under the Plan if they meet the eligibility requirements described in this section. The Employee must be a full-time Employee of an employer for which contributions are made by that employer to the Plan pursuant to a written agreement. For these purposes only, a full-time Employee shall be an Employee who works for that employer at least forty (40) hours per week. Further, payments for such Employee must be received by the Plan at least fifteen (15) days prior to the coverage for the next month in an amount equal to such rate as agreed upon by the Plan and that employer pursuant to a written agreement. The self-contribution provisions in this Plan shall not apply to Employees covered in this section.

  The Plan also included the following example to explain this new provision: For illustrative purposes only, assume the Plan and Employer B agreed (pursuant to a written agreement) to a $5.00 per hour

contribution rate for Employer B's employee, Employee C, who works 40 hours per week. In order to have coverage for May for Employee C, the Plan must receive Employer B's contribution by April 15. The amount of the contribution shall be $5.00 x 40 hours/week x 52 weeks/12 months = $866.67.

Finally, the Plan has added a benefit schedule to Exhibit A for Benefits for Employees of Employers Who are Covered by a Participation Agreement. These benefits are the same as those for full coverage participants. This schedule is attached to this SMM for your reference.

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

BENEFITS FOR EMPLOYEES OF EMPLOYERS WHO ARE COVERED BY A PARTICIPATION AGREEMENT

<u>Eligible Active Participants</u>

Death Benefit	Up to $5,000
Accidental Death and Dismemberment Benefit	Up to $5,000
Weekly Accident and Sickness Benefit	$300

<u>Eligible Active Participants And Eligible Dependents</u>

Maximum Annual Benefit: .... $150,000 per person
(per calendar year, for the Basic Health Care Benefits, the Mental Health and Substance Abuse Benefits and the Major Medical Expense Benefit combined)

Hospital Room and Board Benefit .... Paid in Full*
(60 days per confinement; semi-private room rate)

Hospital Miscellaneous Charges, including Outpatient Surgery .... Paid in Full*
(60 days per confinement)

The Plan pays for one doctor's visit for participants and dependents over the age of six years old (per year, not including one well woman office visit per year)

Emergency room Doctor's Visits.. Plan pays $75*

Surgical Expense Benefit (listed in Appendix A) .... up to a maximum of $5,000*

Diagnostic Laboratory and X-ray Benefit (maximum per year/per person)................$300*

Emergency Illness Expense Benefit If Subsequently Admitted .... Paid in Full

Emergency Accident Expense Benefit .... Paid in Full

Elective Abortion

Maximum Plan payment for Hospital expenses $500

Maximum Plan payment for Doctor expenses $500

Note: For benefits indicated by a "*", amounts in excess of the limits shown, if any, may be applied to the Major Medical provisions of the Plan.

Outpatient Physical Therapy

Maximum Plan payment per visit $25*

Maximum Plan payment per illness or injury .... $2,000[1]

(note: [1]applies to Basic and Major Medical benefits combined)

Major Medical

Deductible (per calendar year, combined annual deductible on all medical, surgical, mental health and substance abuse disorder benefits)

Per individual $100

Per family $200

Coinsurance .... 80% up to the lifetime maximum, if applicable

Home health care benefits

Maximum days per year 100

Annual Maximum...$75,000 per person per year

Prescription Drugs (generic only) .... in Full, after a $15 copayment for generic drugs and a $25 copayment for brand-name drugs with no generic equivalent (plus the difference in cost if a generic equivalent is available)

Annual Maximum ....$30,000 for the injectable prescription drug Interferon; $10,000 for all other prescription drugs

Optical Benefits (per person)... 80% of incurred charges up to $150 per calendar year (annual maximum not applicable to optical benefits for children, however, optical benefits are limited to one eye examination and one pair of glasses per year per eligible child)

Dental Benefits ....up to $700 per family per calendar year

(annual family maximum not applicable to dental benefits for children)

Orthodontia Benefits .... $1,000 per person, per lifetime

(lifetime maximum not applicable to orthodontia benefits for children)

Orthodontia Benefits ....$1,000 per eligible child, per year

Well Child Care Doctor's Visits
The Plan pays for well child care doctor's visits from birth to the age of six years old (per authorized treatment in accordance with the schedule set forth herein).

- **Effective September 1, 2011- New Utilization Management Provider**
  The Board of Trustees of the Carpenters' Local No. 491 Health and Welfare Fund is pleased to announce a new Utilization Management ("UM") provider.

  Starting September 1, 2011, American Health Holding ("AHH") will replace Nationwide Better Health as your new Utilization Management ("UM") provider. This is the provider which certifies your inpatient hospital stays. There are no changes to your benefits.

  Starting September 1, 2011, you must contact AHH at (800) 641-5566 to pre-certify ALL non-emergency or elective hospital stays and within 24 hours after an emergency admission.

  The Board of Trustees believes this is a positive change and that AHH will provide superior service to the Fund's participants. If you have questions about this change, call the Fund Office toll free at (888) 494-4443.