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SUMMARY OF MATERIAL MODIFICATIONS
NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

To: Active and Retired Participants of the New York City District Council of Carpenters Welfare Fund and their Eligible Dependents

From: Board of Trustees

Date: December 2016

Re: **NYCDCC Welfare Fund Plan Changes**

This Summary of Material Modifications ("SMM") is intended to notify you of important changes to the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund"). Please read this SMM carefully and share it with your family. You should keep it with your Welfare Fund Summary Plan Description ("SPD") and other SMMs. The effective dates of the changes are noted in each section of this SMM.

Covered Preventive Services

As you may know, the Plan pays 100% of the costs incurred for certain preventive services when those services are provided by an in-network provider. This means that these services are not subject to any deductible, and you do not have to pay any cost-sharing amounts (in other words, you do not have to pay a copayment for these services). You may, however, be required to pay a copayment if the primary purpose of an office visit to a provider is not to receive the preventive service, or for a visit that is billed separately from the preventive service.

The preventive services to which this rule applies are those that are required under the Patient Protection and Affordable Care Act. The required services include the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved. (For a complete list of "A" and "B" Recommendations of the Task Force, see: **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**.)

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).
- Hepatitis B screening for all persons at high risk for infection.
- Preeclampsia prevention: aspirin for pregnant women after 12 weeks.
- Fluoride varnish treatment for all infants and children.
- Intensive behavioral counseling interventions to adults that are obese and have cardiovascular risk factors.

To find out if a particular preventive service is paid at 100% when provided by an in-network provider, contact Empire at (800) 553-9603, or Express Scripts at (800) 939-2091. The list of preventive services covered without cost-sharing changes periodically as the standards change.

Variable Copayment Program for Specialty Medications

Effective January 1, 2017, the Welfare Fund is implementing a "Variable Copayment Program" for certain specialty medications through its Pharmacy Benefits Manager ("PBM"), Express Scripts, in order to maximize the patient assistance that is available from the manufacturer on select medications. This means that copayments for certain specialty medications may be set to the maximum out-of-pocket amount or the maximum available manufacturer-funded copayment assistance they are willing to provide. Through the patient assistance program, your true net copayment will be no more than the standard copayment for the plan, but in many cases lower. *Please note that patient assistance received from manufacturers to offset the cost of the medication will not be considered as true out-of-pocket for members and may not apply to deductible and out-of-pocket maximums. For more information concerning specialty medications, please refer to the "Prescription Drug Program" section of your SPD or call Express Scripts at (800) 939-2091.

Maximum Allowed Amount for Out-of-Network Hospitals or Facilities Outside of Empire's Network Service Area

Effective September 1, 2015, the Maximum Allowed Amount for Out-of-Network Hospitals or Facilities outside of Empire's Network service area is as follows.

Network Status

The Maximum Allowed Amount varies depending upon whether the Provider/Hospital/Facility is In-Network or Out-of-Network. **Effective September 1, 2015, the Maximum Allowed Amount also varies depending on whether the Out-of-Network Hospital/Facility is inside or outside of Empire's Network service area.**

For Covered Services performed by an In-Network Provider/Hospital/Facility, the Maximum Allowed Amount is the rate the Provider/Hospital/Facility has agreed with Empire to accept as reimbursement for the Covered Services. Because In-Network Providers/Hospitals/Facilities have agreed to accept the Maximum Allowed Amount as payment in full for that service, they should not send you a bill or seek to collect amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible or have a Copayment or Coinsurance. Please call Empire's Customer Service at (800) 553-9603 or visit **www.empireblue.com** for help in finding an In-Network Provider/Hospital/Facility**.**

Providers/Hospitals/Facilities who have not signed any contract with Empire and are not in any of Empire's networks are Out-of-Network, subject to BlueCross and BlueShield Association rules governing claims filed by certain ancillary Providers.

For Covered Services that you receive from an Out-of-Network Provider, the Maximum Allowed Amount is the lesser of (a) the Out-of-Network Provider's charge or (b) 250% of the reimbursement rate used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually.

In the event that there is no reimbursement rate used by the Centers for Medicare and Medicaid Services for Covered Services that you receive from an Out-of-Network Provider, the Maximum Allowed Amount is the lesser of (a) the Out-of-Network Provider's charge or (b) Empire's Out-of-Network Provider fee schedule/rate which has been developed by reference to one or more of several sources, including the following:

- Amounts based on Empire's In-Network Provider fee schedule/rate;
- Amounts based on charge, cost reimbursement or utilization data; or
- Amounts based on information provided by a third-party vendor, which may reflect one or more of the following factors: (i) the complexity or severity of treatment; (ii) level of skill and experience required for the treatment; or (iii) comparable Providers' fees and costs to deliver care.

Providers who are not contracted for this Medical Plan, but contracted for other plans with Empire, are also considered Out-of-Network. The Maximum Allowed Amount reimbursement for services from these Providers are based on Empire's Out-of-Network Provider fee schedule/rate as described above unless the contract between Empire and that Provider specifies a different amount.

For Covered Services that you receive from an Out-of-Network Hospital or Facility in Empire's Network service area, the Maximum Allowed Amount is the average amounts paid by Empire for comparable services to Empire's Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the Maximum Allowed Amount is the average of amounts paid by Empire for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.

For Covered Services that you receive from non-participating Facilities outside of Empire's Network service area, the Maximum Allowed Amount will be the average amount paid by Empire for comparable services to Empire's Participating Hospitals/Facilities in a service area county designated by Empire. If there are no like kind Participating Hospitals and/or Facilities in that county, then the average of amounts paid by Empire for comparable services in like kind Participating Hospitals and/or Facilities in the closest county to the designated county will be used.

Unlike In-Network Providers/Hospitals/Facilities, Out-of-Network Providers/Hospitals/Facilities may send you a bill and seek to collect the amount of the Provider's/Hospital's/Facility's charge that exceeds the Maximum Allowed Amount. **You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider/Hospital/Facility charges. This amount can be significant.** The Fund has no responsibility to pay any difference between the Maximum Allowed Amount and the amount of charges. Choosing an In-Network Provider/Hospital/Facility will likely result in lower out-of-pocket costs to you. Please call Empire's Customer Service at (800) 553-9603 or visit Empire's website at **www.empireblue.com** for help in finding In-Network Providers/Hospitals/Facilities.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from an Out-of-Network Provider/Hospital/Facility. In order to assist you, you will need

the specific procedure code(s) and diagnosis code(s) for the services at issue. You will also need to know the Provider's/Hospital's/Facility's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

Three-Month Welfare Extension Clarification for Certain Disability Pensioners

Disability Pensioners may be eligible to continue Welfare Fund coverage for up to three months. The following language is intended to clarify when the extension applies.

If your Disability Pension is suspended because you recover or you no longer qualify for a Disability Pension, or you qualify to transition from a Phase I to Phase II Disability Pension but do not have enough vesting credits to continue your Retiree welfare coverage, your Retiree welfare coverage will automatically continue for up to three months.

New Out-of-Network Emergent Claims Process for Empire BlueCross BlueShield

We cannot stress enough the importance of selecting in-network providers for all of your healthcare needs in order to minimize out-of-pocket costs that are not covered by the Welfare Fund. Selecting an in-network provider guarantees the most efficient use of the Plan's limited assets, which in turn means lower increases in health costs that ultimately are paid out of the hourly wage package. Importantly, using an in-network provider also protects you and your family from potentially extremely high bills that can happen when an out-of-network provider "balance bills" you for the portion of charges not covered by the Plan. You can find an Empire participating provider online at **www.empireblue.com**.

We recognize, however, that there may be certain instances where you receive medical care from an out-of-network provider where it may not have been feasible to receive treatment from an in-network provider or facility. It is possible that, during a true medical emergency, an ambulance brings you to the nearest hospital, which may not be a hospital that participates in Empire's hospital network or the BlueCard PPO network if you receive services outside of Empire's operating area. Also, you may be treated by a doctor or other provider in this type of situation who does not participate with Empire or the BlueCard PPO network if you receive services outside of Empire's operating area. In these situations, the hospital or provider will bill you directly for any portion of its bill that exceeds the amount paid by the Welfare Fund and your cost share.

In order to assist you and your family in dealing with unexpected medical bills that result from these involuntary out-of-network charges in emergent situations, the Trustees have authorized Empire to negotiate directly on your behalf with the out-of-network provider or facility to try to settle the balance bill, subject to a number of limitations. If you receive a bill that arises from your involuntary use of an out-of-network provider in an emergent situation, and wish to take advantage of these negotiation services, you will need to contact Empire. You can call Empire at (800) 553-9603 or contact Empire in writing at:

Empire BlueCross BlueShield
Appeals and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Once your inquiry has been filed, Empire will review your claim to determine if it meets Empire's definition of an involuntary emergent out-of-network claim. If Empire determines your claim to meet these criteria, Empire will attempt to reach the provider or facility to negotiate a settlement of up to $25,000, subject to certain limitations specified by the Board of Trustees. If a settlement is reached, Empire will send you a revised Explanation of Benefits indicating that you have no further payment obligation.

It is important to note that this bill negotiation service does **not** guarantee resolution of your claim. In some cases, Empire may determine that the claim in question does not meet its definition of emergent care. In no event will additional payments be made to out-of-network providers in circumstances where Empire determines that you could have received treatment from an in-network provider. In other cases, the provider or facility in question may not be willing to negotiate your claim. In the event that this bill negotiation service does not resolve your claim, you will be contacted by Empire and you then have the right to file a grievance through Empire. If the grievance is upheld, you can file a second level grievance. If the second-level grievance is also upheld, you retain your right to file a voluntary appeal to the Appeals Committee of the Board of Trustees as outlined in your SPD.

Changes to Eligibility for Disability Benefits

In 2015, the Fund issued a restated SPD, dated March 1, 2015, to all Active Participants Working in Outside Construction and Shop Employment (the "Active SPD"). The Active SPD described a change to the eligibility requirements for the continuation of Welfare Fund coverage during periods of disability that went into effect for Active Participants on September 1, 2015. Earlier this year an SMM was also distributed to Disabled Retired Participants, which describes how the revised eligibility requirements applied to retirees and their dependents who were receiving retiree disability coverage from the Welfare Fund. To read this SMM in its entirety, you can visit the following link on our website: **https://nyccbf.com/wp-content/uploads/2016/03/NYCDCC-WF-Disability-Coverage-SMM-Cover-Letter_March-2016_FINAL.pdf**

Automatic Payment Requirement for Retiree Welfare Coverage Premiums

As you may know, Eligible Retirees are required to pay a monthly premium in order to maintain Welfare Fund coverage.

Beginning on July 1, 2016, the Welfare Fund requires all Retirees and Surviving Spouses to enroll in an electronic payment option for payment of monthly premiums. The Welfare Fund allows Retirees to elect to have their premium deducted from (a) their monthly pension check or (b) their checking account through ACH debit.

Correction to Stated Hearing Benefit Copayment for Services Provided by GVS: NYCDCC Welfare Fund SPD for Active Participants Working in Outside Construction and Shop Employment

In the NYCDCC Welfare Fund SPD for Active Participants Working in Outside Construction and Shop Employment, which became effective March 1, 2015, Hearing Benefit services provided by GVS were erroneously stated to have a **$145** copayment. The correct copayment amount is **$150**.

Removal of Plan Exclusions for Gender Transition Services

Effective July 1, 2016, the exclusions in the SPD for (a) services related to or in connection with sex-change procedures and (b) surgery and/or treatment for gender change are eliminated.

Notice of Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

The Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Welfare Fund:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

  ○ Qualified sign language interpreters

  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

  ○ Qualified interpreters

  ○ Information written in other languages

If you need these services, contact the Fund's Civil Rights Coordinator, Gerard Minetello.

If you believe that the Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance via mail with: Civil Rights Coordinator, Gerard Minetello at 395 Hudson Street, 9th Floor, New York, New York, 10014. You can also file a grievance in person, via fax at (212) 366-7444, Attn.- Gerard Minetello, or via email at **GMinetello@nyccbf.org**.

If you need help filing a grievance, Mr. Minetello is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201. You can also file a grievance via phone at 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-529-3863.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-529-3863.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-529-3863.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-529-3863.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-800-529-3863 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-529-3863.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-529-3863.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-529-3863.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-529-3863.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-529-3863.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-529-3863.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-529-3863.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-529-3863.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-529-3863 (رقم هاتف الصم والبكم).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-529-3863.

Questions?

If you have questions for the Fund Office regarding these changes, you can call the Member Services Department at (212) 366-7399, Monday through Thursday from 8:00 a.m. to 5:30 p.m. and Friday from 8:00 a.m. to 5:00 p.m.

The Board of Trustees reserves the right to terminate, suspend, reduce or otherwise modify benefits at any time.