NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS BENEFIT FUNDS

UNION TRUSTEES
Joseph A. Geiger
Co-Chairman

Paul Capurso
Michael P. Cavanaugh
Graham McHugh
Michael Rodin
John Sheehy

David Stewart
Executive Director

395 Hudson Street
New York, NY 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

MANAGEMENT TRUSTEES
David T. Meberg
Co-Chairman

John DeLollis
Kevin O'Callaghan
John O'Hare
Michael Salgo

SUMMARY OF MATERIAL MODIFICATIONS

NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

To: All Fund Participants

From: Board of Trustees of the NYCDCC Welfare Fund

Date: October 2018

Re: Miscellaneous Changes to the NYCDCC Welfare Fund Plan

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.

In-Network Annual Out-of-Pocket Maximum Clarification

Effective January 1, 2017, your Annual Out-of-Pocket Maximum changed. The Schedule of Benefits Chart on page 29 of your SPD, which lists your Annual Out-of-Pocket Maximum, now reads as follows:

ANNUAL OUT-OF-POCKET MAXIMUM (Including Annual Deductible)	$1,900/Individual $4,750/Family	$3,000/Individual $7,500/Family

Acupuncture Added to Schedule of Benefits Chart

Acupuncture has been added to the Schedule of Benefits Chart on page 29 of your SPD, appearing under Chiropractic Care. This addition is reflected in the chart below.

HOME, OFFICE/OUTPATIENT CARE		
HOME/OFFICE VISITS	$20 per primary care visit $25 per specialist visit	30% of Allowed Amount after Deductible is satisfied
SPECIALIST VISITS	$25 per visit	30% of Allowed Amount after Deductible is satisfied

HOME, OFFICE/OUTPATIENT CARE		
CHIROPRACTIC CARE • Up to 45 visits per calendar year	$20 per visit	Not covered
ACUPUNCTURE • Unlimited visits	10% of Network Fee after Deductible is satisfied (a specialty copayment of $25 may apply if the provider bills for an office visit)	30% of Allowed Amount after Deductible is satisfied

Outpatient Precertification Requirement Clarification Regarding Behavioral/Mental Health Care and Alcohol/Substance Abuse Treatment

As shown below, only Non-Routine Outpatient treatments require precertification. This clarification is being made to pages 36 and 37 of your SPD.

BEHAVIORAL/MENTAL HEALTH CARE		
Outpatient • Unlimited number of Medically Necessary visits	$20 per visit	30% of Allowed Amount after Deductible is satisfied
Non-Routine Outpatient (*precertification required) • Includes Intensive Outpatient ("IOP"), Partial Day Hospital ("PHP"), and Applied Behavioral Analysis	$20 per visit	30% of Allowed Amount after Deductible is satisfied
Inpatient • Unlimited number of Medically Necessary days • Unlimited number of Medically Necessary visits from mental healthcare professionals	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

ALCOHOL OR SUBSTANCE ABUSE TREATMENT		
Outpatient • Unlimited number of Medically Necessary visits, including visits for family counseling	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
Non-Routine Outpatient (*precertification required) • Includes Intensive Outpatient ("IOP"), Partial Day Hospital ("PHP")	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
Inpatient • Unlimited number of Medically Necessary days of detoxification • Unlimited number of Medically Necessary rehabilitation days	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

Habilitation Services Added to Schedule of Benefits Chart

Habilitation Services have been added to the *Physical Therapy and Rehabilitation* heading of the Schedule of Benefits chart on page 36 of your SPD. This addition is reflected in the following chart.

PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY (precertification required)		
PHYSICAL THERAPY, REHABILITION, AND HABILITATION • Up to 30 days of inpatient service per calendar year	10% of Network Fee after Deductible is satisfied	Not covered

Bariatric Surgery Added to What's Covered Section for Inpatient Hospital Care

Bariatric surgery (based on Medical Necessity and medical policy) has been added to the *What's Covered* section for Inpatient Hospital Care on page 46 of your SPD.

Changes to Emergency and Urgent Care Section

The following changes have been made to the *Emergency and Urgent Care* section of your SPD:

- Page 41- The sentence, "You pay a Copayment for a visit to an emergency room" now reads as follows: "You pay a Copayment for a visit to an emergency room *if your annual deductible and out-of-pocket maximum have not been met."*

- Page 42- The *Urgent Care* section has been revised to read as follows:
  "Urgent care is care required in order to prevent serious deterioration to your health. It is the type of care that requires timely attention (i.e., bronchitis, high fever, sprained ankle), but is not an emergency. Urgent care is covered in an urgent care center or in your physician's office.

***For urgent care**, you may receive In-Network or Out-of-Network Benefits. If you visit an In-Network doctor or urgent care center, you must pay a Copayment. If you visit an Out-of-Network doctor or urgent care center, you pay a Deductible and Coinsurance."*

Additional Documentation Requirements for Adding Eligible Spouses to Health Coverage

Effective January 1, 2018, if you wish to add your eligible spouse to your health coverage and ***if your marriage certificate <u>DOES NOT</u> state your spouse's date of birth***, you must provide a copy of your spouse's birth certificate. In all cases, you must provide copies of your marriage certificate and your spouse's social security card**.**

Addition to Confidentiality Language

Effective January 1, 2018, an additional sentence should be noted in the second paragraph of the *Confidentiality* section on page 112 of your SPD. The new paragraph should read as follows:

The term "Protected Health Information" ("PHI") includes all individually identifiable health information related to your past, present or future physical or mental condition or payment for health care. PHI includes all information maintained by the Fund in oral, written or electronic form (except for any information that is received in connection with the Life Insurance or Disability benefits). ***While these items are not PHI under HIPAA, the Fund Office generally treats them as confidential and will not disclose the information without consent, or as required by law or as necessary in connection with claims for life insurance benefits in which case a beneficiary designation may be disclosed to an individual applying for life insurance benefits.***

Removal of Psychological Testing from Precertification Chart

Psychological Testing has been removed from the *Before You Receive/Use* section of the precertification chart on page 57 of your SPD.

Removal of Precertification Requirement for Cardiac Rehabilitation

The "precertification required" bullet point that appears underneath the *Cardiac Rehabilitation* heading on page 30 of your SPD in the Schedule of Benefits chart has been removed. Cardiac Rehabilitation does **NOT** require precertification.

Reminder Concerning Precertification Requirement for Certain Outpatient Services

Certain outpatient services require precertification. Before you schedule a procedure, please ask your provider to contact Empire's Medical Management at (844) 416-6387 to see if that procedure requires precertification. Failure to precertify may result in a penalty and/or denial of the claim if the service is not deemed to be medically necessary.

Changes and Clarifications to Review/Appeal Process

On page 117 of your SPD, the *Review Process* section has been renamed "Appeal Process." We have also added a chart to assist you in filing appeals. The revised section follows:

Appeal Process

If a claim is denied (in whole or in part) and you disagree with the decision, you or your authorized representative may appeal. The amount of time you have to appeal, and levels of appeal are summarized in the following chart:

Type of Benefit	Where to Send Appeal	Allowable Amount of Time to Submit Appeal
Dental	**First Level**- ASO/SIDS **Voluntary Second Level**- Appeals Committee of the Board of Trustees ("Appeals Committee")	**First Level**- Within **180** days of notice of adverse benefit determination **Voluntary Second Level**- Within **60** days of notice of denial of First Level Appeal
Hospital, Medical, and Behavioral Health	**First Level**- Empire **Second Level**- Empire **Optional Third Level**- Appeals Committee	**First Level**- Within **180** days of notice of adverse benefit determination **Second Level**- Within **60** days of notice of denial of First Level Appeal **Optional Third Level**- Within **60** days of notice of denial of Second Level Appeal
Prescription Drugs	**First Level**- Express Scripts **Second Level**- Express Scripts **Optional Third Level**- Appeals Committee	**First Level**- Within **180** days of notice of adverse benefit determination **Second Level**- Within **60** days of notice of denial of First Level Appeal **Optional Third Level**- Within **60** days of notice of denial of Second Level Appeal
Short-Term Disability, Vision, Hearing	Appeals Committee	Within **180** days of notice of adverse benefit determination
Life Insurance, AD&D	Appeals Committee	Within **180** days of notice of adverse benefit determination

Changes to Dental Appeals Sections

The dental appeals section, beginning on page 132 in your SPD, has been updated to reflect the change in providers from Aetna to ASO/SIDS. The new dental appeals section is as follows:

Dental Appeals

There is one mandatory first level appeal to ASO/SIDS and an optional second level appeal to the Appeals Committee.

Time Frames for Appeals Decision-making

After you submit a first level mandatory appeal to ASO/SIDS, ASO/SIDS will complete its review of your appeal and notify you of its decision within **60 days** of receipt of the appeal.

Your appeal to ASO/SIDS must be made in writing. No verbal appeals will be accepted.

If ASO/SIDS denies your appeal, you then have the option to appeal to the Appeals Committee. To avail yourself of the optional appeal, it must be filed within 60 days of the date of the decision of ASO/SIDS' appeal.

You are not required to file an optional appeal to the Appeals Committee in order to fulfill your appeal procedure obligations. Your decision whether to file such an appeal will not affect your rights to any other benefits under the Welfare Fund. The Committee's decision is final and binding on all parties except for any relief available through ERISA.

Your appeal to the Appeals Committee must be made in writing. No verbal appeals will be accepted. Once the appeal is received, the Appeals Committee will verify if ASO/SIDS has previously issued a denial. If you have not timely filed an appeal with ASO/SIDS, you will have forfeited your right to an optional appeal to the Appeals Committee.

In order to utilize the optional appeal to the Appeals Committee, your appeal must be received within **60 days** of the date of ASO/SIDS appeal decision. If the appeal is not submitted within that time frame, the Appeals Committee will not review it and ASO/SIDS's decision will stand**.** The Appeals Committee will complete its review of your appeal at its next regularly scheduled meeting following receipt of your written appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal.

Questions?

If you have questions for the Fund Office, you can call the Member Services Department at (800) 529-FUND (3863), 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.

This SMM contains only highlights of certain features of the New York City District Council of Carpenters Welfare Fund. Full details are contained in the SPD and other SMMs. The Board of Trustees reserves the right to terminate, suspend, reduce or otherwise modify benefits at any time.