Ohio Carpenters' Fringe Benefit Funds

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This letter serves as a summary of material modifications of the Plan.
Please keep this with your Summary Plan Description.

* Important Health Plan Benefit and Premium Changes *

March 2018

To All Participants of the Ohio Carpenters Health Plan

Dear Participant:

The Board of Trustees has made changes to the Plan's monthly premiums and self-payment rates. The new rates will take effect on **July 1, 2018** (except as otherwise noted) and are as follows:

	Old Rate	New Rate
Active Participants		
Collectively Bargained	$860 (contributions exceeding $960 during a month will be credited to the Participant's dollar bank)	$890 (contributions exceeding $990 during a month will be credited to the Participant's dollar bank)
Not Collectively Bargained	$960	$990
COBRA Participants (new rates effective May 1, 2018)		
Full Coverage (effective May 1, 2018)	$1,008	$954
Medical and Rx Only (effective May 1, 2018)	$765	$907
Retirees with at least One Covered Family Member Not Eligible for Medicare		
All Coverages	$860	$890
Retirees with All Covered Family Members Eligible for Medicare		
Medicare Supplement + EGWP Rx [Single Coverage]	$186	$236
Medicare Supplement + EGWP Rx [Family Coverage]	$372	$472
Medicare Supplement Only (no Rx coverage) [Single Coverage]	$136	$186
Medicare Supplement Only (no Rx coverage) [Family Coverage]	$272	$372
Medicare Supplement + PDP Rx [Single Coverage]	$161	$211
Medicare Supplement + PDP Rx [Family Coverage]	$322	$422
Medicare Supplement + PDP Rx for One Covered Family Member (all others have no Rx coverage) [Family Coverage]	$297	$397
Medicare Supplement + EGWP Rx for One Covered Family Member (all others have no Rx coverage) [Family Coverage]	$297	$422
Medicare Supplement + PDP Rx for One Covered Family Member + EGWP Rx for all others [Family Coverage]	$347	$447

The Trustees also made Plan changes which will take effect on **May 1, 2018**. Those changes are as follows:

FOR ACTIVE AND PRE-MEDICARE PARTICIPANTS AND DEPENDENTS

Initial Eligibility

The initial eligibility rules were modified so that the Dollar Bank requirement must be met within 12 months.

Life Insurance Beneficiary

Plan language was added to specify that, upon divorce, the designation of a spouse as beneficiary is automatically null and void unless the Participant re-designates the ex-spouse after the divorce.

Prescription Maximum Out of Pocket Cost

Plan language was added to note that there is an annual maximum out of pocket cost for prescription drugs purchased with participating pharmacies, which will be adjusted annually. This maximum is the difference between the maximum out of pocket cost permitted for combined medical and prescription drugs as established by Health Care Reform and the maximum out of pocket for in-network medical set forth in the Chart of Benefits contained in your Summary Plan Description (SPD). For example, the 2018 out of pocket maximum cost permitted for combined medical and prescription drugs as established by Health Care Reform is $7,350 for single coverage and $14,700 for family coverage. The maximum out of pocket for in-network medical set forth in the Chart of Benefits in the SPD (and the enclosed Summary of Benefits and Coverage) is $3,000 for single coverage and $6,000 for family coverage. Therefore, the 2018 maximum out of pocket cost for prescription drugs purchased with participating pharmacies is $4,350 for single coverage and $8,700 for family coverage. There is no out of pocket maximum cost for drugs obtained from non-participating pharmacies.

Diabetic Management Program

Plan language was added to note that diabetic testing supplies are provided to the Covered Person without cost sharing. A list of covered diabetic test supplies is available at the Plan Office, and currently includes blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketene test strip, and insulin pumps.

Emergency Room Benefits

Plan statistics show that many patients utilize the emergency room for injuries and illnesses that do not require the emergency room and could be treated more cost effectively. In order to encourage participants to take advantage of the Live Health On-Line visits as well as Urgent Care Centers and Retail Clinics (such as Walgreen's, CVS, etc.) the following change was made:

Hospital Emergency Visits will now be subject to a $250 copayment. The copayment will be waived if you are admitted to the hospital or if the visit was necessary due to an injury or life threatening event. After the copay is satisfied, benefits will be paid at 80%.

Weekly Disability Benefit

The Plan was changed to specify that the Weekly Disability Benefit is only available to those Participants who are active at the time the injury occurred. In addition, the filing limit for a Weekly Disability Benefit claim was changed from 90 days after the date the injury occurred to 90 days after the date a physician certifies the disability.

Precertification Services

Language was added to the Plan to clarify that American Health Holding (AHH) has been retained to provide precertification services on behalf of the Fund. The participant is not responsible for this as the provider should contact AHH for the precertification.

Private Duty Nursing

The Plan was changed to add an annual 90-day visit limitation for private duty nursing.

Mental Health Benefits for Inpatient Residential Treatment Center Services
The Plan was changed to require precertification prior to being admitted as an inpatient to a residential treatment facility and to only cover these services at **in-network facilities**. The Plan will no longer cover out-of-network facilities for inpatient stays.

Services Provided in Conjunction to Office Visits
Routine preventive office visits are covered at 100% under the Plan in accordance with Health Care Reform. The Plan language was changed to clarify that other services received during the office visit will be subject to the deductible and applicable coinsurance.

Skilled Nursing Facilities for In-Patient Stays
The Plan was changed to limit benefits on in-patient stays at Skilled Nursing Facilities to only in-network facilities. The Plan will no longer cover out-of-network facilities for in-patient stays.

Speech Therapy, Occupational Therapy and Physical Therapy
The Plan was changed to clarify that these therapies combined will have a maximum of 70 visits per year.

Transplant Coverage
The Plan language was changed to clarify that all transplants must be precertified in advance.

Cosmetic Surgery or Subsequent Treatment Due to the Cosmetic Surgery
The Plan has always excluded benefits for cosmetic surgery. The Plan language was changed to also exclude any subsequent treatment necessary due to the cosmetic surgery. For example, if a participant has a non-covered breast implant surgery and later needs surgery to correct a problem with the implant, the corrective surgery will also be excluded.

Sterilization
The Plan currently provides 100% coverage for women for sterilization. The Plan was changed to also provide 100% coverage for men for sterilization. Reversal surgeries which are medically necessary will be covered under the normal Major Medical Benefit with deductibles and coinsurance required.

Genetic Testing
The Plan was modified to cover genetic testing if it is medically necessary to determine the course of treatment for currently active, ongoing medical conditions.

Prescription Contraceptives
The Plan was changed to provide coverage of prescription contraceptives for Dependents.

Immunizations
The Plan language was modified to clarify that the coverage for immunizations includes all immunizations required to be covered by Health Care Reform. The Shingles vaccine will be covered in accordance with the Center for Disease Control (CDC) or for those over 50 if documentation can establish the medical necessity for deviating from the guidelines. Rabies and Pneumonia immunizations will follow the CDC guidelines.

Statute of Limitations
The language for the Statute of Limitations has been modified to reduce the time period for filing legal action against the Plan from three years after the time written proof of loss is required to be furnished to 180 days after the time written proof of loss is required to be furnished.

FOR MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

Medicare Supplemental Coverage

Emergency Services Outside of the Country

The Plan was modified to provide coverage for emergencies while a Participant or Dependent is outside the United States for a period no longer than 30 consecutive days (i.e. a vacation) and payment limited to no more than the Plan would have paid for a non-Medicare eligible person for similar in-network treatment in that country. This change was made to accommodate the fact that Medicare has no coverage outside the United States.

Skilled Nursing

The Plan was changed to specify that the Plan will not cover Skilled Nursing after the retiree has exhausted the Medicare benefit period. For example, Skilled Nursing is covered for 100 days under Medicare. As such, the Plan will also limit the benefit to the 100 days as set by Medicare.

Private Duty Nursing

The Plan was changed to specify that Private Duty Nursing is treated the same as any other benefit provided through this Plan's Medicare Supplement program. The Plan previously had a $1,000 per year limit. That limit has been removed and the Plan will now pay Supplemental Benefits for Private Duty Nursing services approved by Medicare.

If you have any questions regarding these changes, please contact the Fund Office at 1-800-700-6756.

Sincerely yours,

Board of Trustees