CENTRAL STATES JOINT BOARD HEALTH & WELFARE PLAN

Summary of Material Modifications

On June 15, 2016, your Board of Trustees made changes to your Plan of health benefits. These changes are necessary to keep the Fund on a sound financial basis and to ensure its ability to provide healthcare benefits during this time of continual increases in the cost of medical care and prescription drugs.

This Summary of Material Modification (SMM) describes the modifications to your Plan. This SMM is effective for all claims incurred on or after January 1, 2017. Please keep this SMM along with your other important papers relating to benefits provided to you and your eligible dependents by the Board of Trustees of the Central States Joint Board Health & Welfare Fund.

Out-of-Network Coverage

Out-of-Network services are among the most costly services covered by the Fund. The Trustees realize that it is important to have access to primary care physicians and specialists, so the Fund contracted with Blue Cross/Blue Shield to utilize their vast PPO Network. Because of the exploding costs of Out-of-Network Services and the large PPO network available to Fund participants and beneficiaries, the Trustees have decided to eliminate coverage for Out-Of-Network providers, except for Emergency Room services. Of course, if you live more than 30 miles from an In-Network Hospital, the Fund will still provide coverage for Out-of-Network services.

The specific provisions of the SPD that have been changed are listed below:

Under DEFINITIONS:

Covered Expense is the cost of Medically Necessary, non-Experimental services or supplies that Participants and eligible Dependent(s) are entitled to receive under the terms and conditions of the Plan which shall be, with respect to an In-Network Health Care Provider that is party to an agreement to provide services or supplies to Covered Persons, the charge agreed to by the Provider under such agreement; or with respect to an Out-of-Network Emergency Room Provider, the lowest of:

1. the usual charge by the Emergency Room Provider for the same or similar service or supply; or

2. the usual, customary and reasonable fee, as determined by the Fund in its sole and exclusive discretion, which is regularly charged and received for a given service by an Emergency Room Provider which does not exceed the general level of charges being made by providers of similar training and experience when furnishing treatment for a similar Illness or Injury. The locality where the charge is incurred is also considered.

3. In no event shall any Covered Expense exceed the maximum rate that the Fund has determined will be paid for the service or supply.

Under SCHEULE OF BENEFITS

	IN-NETWORK PPO and OUT-of-AREA	**OUT-of-NETWORK**
Calendar Year Deductibles		
Individual Medical Deductible	$700	Not Covered
Maximum Family Medical Deductible	$2,100	Not Covered
Individual Prescription Drug	$0	Not Covered
See Pages 22 and 40		
Medical Maximum Out-of-Pocket Expense		
Per Covered Individual (After Deductible)	$2,800	Not Covered
Per Family	$8,400	Not Covered
Co-insurance (Cost Sharing)	Fund Pays 80%	Not Covered
	Claimant pays 20%	Not Covered

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
See Page 22		
Prescription Drug Maximum Out-of-Pocket Expense		
Per Covered Individual (After Deductible)	$2,000	Not Covered
Per Family	$2,700	Not Covered
See Page 40		
Calendar Year Maximum Benefits		
Specific Calendar Year Maximums apply to certain expenses. They are:		
TMJ Disorder	$500	Not Covered
Chiropractic Services	$500	Not Covered
Podiatry/Foot surgery	$2,000	Not Covered
See Pages 16-20		
Lifetime Maximum Benefits		
Specific lifetime maximums apply to certain expenses, they are:		
TMJ Disorder Maximum	$2,000	Not Covered
Fertility/Conception/Impotence Max.	$5,000	Not Covered
See Pages 16-20		
Hospital Pre-Admission Testing		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 27		
Hospital In-Patient Confinements		
Calendar year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 26	$500 Paid by the Claimant if the procedure is not pre-certified. The $500 co-pay is not part of your deductible or out of pocket expenses.	Not Covered
Hospital Out-Patient Treatment Services & Supplies		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 27		
Hospital Room Services & Supplies		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Co-Pay Applies?	Fund pays 80% Claimant pays 20%	Not Covered
See Page 39		
Emergency Room Services		
Calendar Year Deductible Applies?	YES	YES
Out-of-Pocket Coinsurance	Fund pays 80%	Fund pays 80%
	Claimant pays 20%	Claimant pays 20%
Emergency Room Co-Pay	$200	$200
The co-pay will be waived if hospital confinement follows within 48 hours of the ER visit. The $200 co-pay is not part of your deductible or out of pocket expenses.		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
See Page 38		
Surgi-Centers, Ambulatory Surgery Centers, Free Standing Surgery Facilities		
Calendar Year Deductible Applies?	YES	NO
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	
See Page 29		
Doctors Visits (Medical and Surgical)		
Calendar Year Deductible Applies?	NO	Not Covered
Primary Care Physician	Claimant pays $25	Not Covered
Specialist	Claimant pays $50	Not Covered
See Page 24		
Laboratory & Diagnostic Testing		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 24		
Mandatory Outpatient Surgery	$500 Paid by the Claimant if the procedure is not pre-certified. The $500 co-pay is not part of your deductible or out of pocket expenses.	Not Covered
See Page 29 for a list of outpatient surgeries		
Physical/Occupational/Speech Therapy		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 32		
Podiatric Care/Foot Surgery		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund Pays 80%	Not Covered
	Claimant pays 20%	Not Covered
Calendar Year Maximum	$2,000	Not Covered
See Page 30		
Chiropractic Services		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
Calendar Year Maximum	$500	Not Covered
See Page 30		
Special/Medical Equipment or Appliances		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 31		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Organ Transplants (Covered Person MUST get prior approval from Case Management Services before any treatment is rendered.)		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 39		
Preventative Care/Wellness Benefits		
Calendar Year Deductible Applies?	NO	Not Covered
Out-of-Pocket Coinsurance	Fund pays 100%	Not Covered
	Claimant pays 0%	Not Covered
See Page 35		
Hospice Care for the Terminally Ill Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20% IF Hospice Care is arranged thru Case Management Service. If Case Management Service is not involved, the Fund will pay 70% and the Claimant must pay 30%.	Not Covered
See Page 48		
Home Health Care Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20% IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, and the Fund will pay 70% and the Claimant must pay 30%.	Not Covered
Calendar Year Maximum	60 visits IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, the benefit is limited to 40 visits	Not Covered
See Page 48		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Skilled Nursing Facility		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20% IF Skilled Nursing is arranged thru Case management Service. If Case Management Service is not involved, the Fund will pay 70% and the Claimant must pay 30%.	Not Covered
Calendar Year Maximum	150 Confinement Days IF Home Health Care is arranged thru Case Management Service. If Case Management Service is not involved, the benefit is limited to 120 days	Not Covered
See Page 47		
Fertility/Conception/Organic Impotence Benefit Benefits are for the Employee and eligible Spouse only. Dependent children are not eligible for these benefits		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
Lifetime Maximum Benefit	$5,000	Not Covered
See Page 33		
Temporomandibular Joint Dysfunction (TMJ) Disorder		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
Calendar Year Maximum Benefit	$500	Not Covered
Lifetime Maximum Benefit	$2,000	Not Covered
See Page 30		
Preventative Services The Fund provides certain preventative services for adults and children.		
Calendar Year Deductible Applies?	No	Not Covered
Out-of-Pocket Coinsurance	Fund pays 100%	Not Covered
	Claimant pays 0%	Not Covered
See Page 35		
Mental Health/Alcoholism and Substance Dependency Combined Benefit		
Inpatient Benefit		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 34		

	IN-NETWORK PPO and OUT-of-AREA	OUT-of-NETWORK
Outpatient Benefit		
Calendar Year Deductible Applies?	YES	Not Covered
Out-of-Pocket Coinsurance	Fund pays 80%	Not Covered
	Claimant pays 20%	Not Covered
See Page 34		
Prescription Drug Benefit **Mail and Non-Mail Service Program**	IN NETWORK	MAIL ORDER
Out-of-Pocket Coinsurance You cannot file a claim to collect the coinsurance amounts for Prescription Drug Benefits under the Mail Service Program	Claimant pays 10% for each Generic Rx Claimant pays 35% for each Brand Name Rx plus 100% of the cost difference for each Brand Name Rx when a generic Rx is available Claimant's maximum copay for each filled prescription is $200	Claimant pays 10% for each Generic Rx Claimant pays 35% for each Brand Name Rx plus 100% of the cost difference for each Brand Name Rx when a generic Rx is available Claimant's maximum copay for each filled prescription is $200
See Page 40		
	OPTUMRX SPECIALTY PHARMACY	
Specialty Drugs ***You must use the OptumRx Specialty Pharmacy to receive specialty drug benefits***	Claimant pays 20% for each Specialty Rx, maximum copay of $250	

Under COMPREHENSIVE MAJOR MEDICAL PLAN OF BENEFITS:

Family Maximum Deductibles

If more than one Covered Person in the same Immediate Family has injuries or illnesses in any Calendar Year, the total of the Deductibles incurred by the family could be a financial burden. To ease this burden, the Plan provides a maximum family limit on Deductibles of $2,100 for covered services provided by PPO Network providers.

Co-Payments and Coinsurance

Co-payments and Coinsurance are those parts of the charges you pay Out-of-Pocket for Covered Medical Expenses. Typically, for expenses you incur at a PPO Network provider your Out-of-Pocket Co-Payment is 20%, the Plan pays the remaining 80% after your Calendar Year Deductible (if applicable) is met. Please refer to the Schedule of benefits for details of the Coinsurance requirements.

Your Out-of-Pocket Expenses Are Limited

The Plan places a limit on the amount of out-of-pocket expenses you have to pay each Calendar Year for your share of Covered Medical Expenses.

For Covered Medical Expenses you or your Dependent incur at PPO Network Hospitals, Physicians or other medical providers, the Out-of-Pocket Coinsurance limit is $2,800 for each Covered Person and $8,400 for your entire family.

Note: These Out-of-Pocket Coinsurance limits **do not** include the Calendar Year Deductible amount that must be paid before the Plan provides benefit payments.

After you reach the Out-of-Pocket Co-Payment limit in a Calendar Year for each Eligible Covered Individual, the Plan will pay 100% of the remaining Medically Necessary, Reasonable and Customary Covered charges for the rest of that Calendar Year.

The amount of the Deductibles, Co-Payments or Coinsurance is based on health care costs and may change from time to time. You will be notified of any such changes.

What This Means

This means that if you use **only** PPO Network hospitals, Physicians and other Medical Providers the Maximum you will pay Out-of-Pocket in a Calendar Year for each Covered member of your family is **$700** for the Deductible and **up to $2,800** in Co-Payment expenses **for a total of $3,500**.

Reasonable and Customary Charges

The Plan considers for payment only the Reasonable and Customary Charges (R&C) for Medically Necessary Covered Medical treatment, services and supplies you and your Covered Dependents receive.

If your provider's charges or any Covered Expenses are greater than the R&C, you may have to pay the difference.

However, if you use PPO Network Physicians, these Physicians have agreed to accept the Plan's R&C payment, and you should not be billed for any additional R&C charges.

Under YOUR CHOICES FOR MEDICAL BENEFITS:

The Plan has arranged through contracts with Preferred Provider Organizations to provide a network of hospitals, physicians, surgeons, diagnostic centers, labs and other medical care providers. These providers have agreed to charge lower fees for the healthcare services provided to you and your eligible Dependents. This network of providers is referred to as the **In-Network PPO. Except for Emergency Room treatment, the Fund only provides benefits for services rendered by an in-network provider.**

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If you do not use an **In-Network PPO** provider, your claim will not be covered, and you will have to pay the claim out of your own pocket.

If your current family Physician is not a PPO provider, you can contact the Preferred Provider Organizations or the Fund Office with his name, address and phone number. The Preferred Provider Organizations may invite your family Physician to join the PPO. If he does, you will receive the benefits. If he does not join, you may choose to continue with this Physician and receive no benefits or you can select another Physician from the PPO listing.

Not all Physicians affiliated with PPO Hospitals are in the PPO Network. Again, you should call the Preferred Provider Organizations or the Fund Office to ensure that the Physician selected is in the PPO Network. If the Hospital is a PPO Hospital but the Physician used is not, you will receive benefits for the Hospital stay, but you will be required to pay the Out-of-Network Physician. The same applies if the Physician is a PPO provider but the Hospital used is Out-of-Network.

Out-of-Area Covered Participants

For Covered Individuals who live in rural areas that do not have a PPO Hospital within thirty (30) mile radius of their home, the Fund will consider those individuals as **"Out-of-Area"** and treat their covered medical expenses as if they had used the In-Network PPO medical providers.

Under DOCTOR VISITS:

You can choose your Primary Physician for your medical care. If your Doctor is covered by the Plan's **In-Network PPO,** you pay only $25 for visits to your Primary Physician and $50 for visits to any specialist. If your Doctor is not covered by the Plan's **In-Network PPO,** you pay 100% of the charges for any visit to your Primary Physician and/or any specialist.

Under MAJOR MEDICAL HOSPITAL BENEFITS

Covered Benefits When You Go Into the Hospital

When you go into the Hospital, the Plan pays most of your Covered Expenses. However, you must meet the applicable Calendar Year Deductible before benefits are paid.

After you meet the Deductible, the Plan pays its portion of the Reasonable and Customary charges for Medically Necessary Covered Medical Expenses as listed on the Schedule of Benefits, Pages 13 through 21.

Remember, if you use Out-of-Network Hospitals you receive no benefits.

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Outpatient Hospital Benefits

Covered medical services performed by a Hospital on an Outpatient basis, or at a Covered Surgi-center, Urgent Care Center or Ambulatory Center or a Covered Outpatient Facility are subject to the Calendar Year Deductibles, applicable Co-Payments and Major Medical provisions of the Plan.

Remember, covered services received at Out-of-Network Facilities and by Out-of-Network providers are not covered.

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If You Need Surgery

The Plan pays, subject to the Calendar Year Deductible, its portion of the Reasonable and Customary Medically Necessary Covered Expenses for the Physician, surgeon and assistant surgeon (except for Podiatric Surgery).

If you use Out-of-Network providers, you will receive no benefits.

Call the Plan's Case Management Medical Care Review Program at 1-800-810-2752 as soon as your surgery is scheduled.

Pre-Certification of Health Care

Effective January 1, 2017, you must contact the Fund's Case Management Medical Care Review Program for pre-certification prior to incurring expenses for Dialysis and Imaging. Once you have provided the necessary information, Case Management will evaluate the proposed services based on your individual treatment needs.

If you do not contact the Case Management Medical Care Review Program prior to incurring such expenses, all charges incurred will be subject to a $500 penalty. The penalty may not be applied towards your deductible, co-insurance, co-payments or out-of-pocket maximum.