

Summary of Material Modifications

Listed below is a summary of modifications to the Health and Welfare Plan Document and Summary Plan Description that have been adopted and approved *after* January 1, 2006. These modifications are provided to alert you of plan provisions that are not listed in your new Summary Plan Description or have since changed. Please keep this document with your book.

Effective January 1, 2006

1. "MULTIPLE COVERAGE LIMITATIONS," Appendix B, page 69; the term "Plan" no longer includes medical benefits coverage, often referred to as Med Pay, under individual insurance policies in the definition; specifically homeowners and automobile.
2. Medicare Supplemental Coverage, page 35; Medicare Supplemental Coverage does not include prescription drug coverage for persons enrolled in other Medicare Part D drug plans or subsidies.

Effective March 1, 2006

1. "**Special Co-Payment for Diabetes Supplies**" on page 29 and Appendix G on page 89; benefits for name-brand injectable insulin, insulin syringes, test strips, alcohol swabs and lancets will be paid by applying the 20% generic co-pay in all cases.

Effective May 1, 2006

1. Exclusions & Limitations, Medical Plan page 33, #6; "dental implants" are approved for coverage to replace lost sound teeth if all the following conditions are satisfied:
 - The teeth are lost as a result of an accident or injury, a covered illness, or treatment of a covered illness; and
 - The loss of teeth occurs, and the implant charges are incurred, during the period of eligibility for benefits.

Effective January 1, 2007

1. Under the heading "Reinstatement Provisions – Non-Active Classification", "Payment for Coverage under Non-Active Classification", page 12, the grace period for self-pay participants is modified from 30 days to 15 days. Participants will be notified 15 days prior to their due date (1st of the month), allowing payments through the 15th of the following month.
2. Under the heading "Difference or Minimum Payments" under "Self-Payment provision – Active Classification", page 9, payments approved to make monthly payments, with a grace period of 15 days.
3. "Termination of Coverage" rules for dependents, page 8, are amended to allow for termination of coverage at the end of the month in which the qualifying termination event occurs.
4. Dental Care Benefits to include "dental implants" approved to be considered as billed instead of applying the alternate treatment allowable to calculate the allowable. The following allowable amounts have been added to the Dental Fee Schedule, page 75, as of 1/1/07:

Surgical Implants

	CDT CODE	ALLOWABLE
Single Implant	D6010, D6040, D6050	\$440
Double Implant	D6010, D6040, D6050	\$645
Three+ Implant	D6010, D6040, D6050	\$850

Final Restorations

Single Crowns	D6058 through D6067	\$302
Overdenture, fixed	D6078, D6079	\$311
Overdenture, removable	D6053, D6054	\$311

All other implant services within the Implant Services category D6000-D6199 will remain "By Report" codes and would require review before payment is made by the Plan.

5. Article VI, page 40; for purposes of Weekly Sickness and Accident benefits, the definition of a legally-qualified physician does not include the care under a chiropractor (DC).

Effective January 1, 2008

1. In Article I, under heading “**Eligibility Classes**”, (page 5); the following is added to the end of the third bullet point.

Each condition must be met for Non-Bargained Office Employee coverage:

- The employer must be obligated to contribute for one or more employees working under a collective bargaining agreement; The employer must execute a participation agreement for Non-Bargained Office Employee coverage on terms acceptable to the Trustees; The employer must be accepted by the Trustees in their discretion; The employer must agree to contribute at the uniform monthly rates established by the Trustees from time to time on behalf of all of the employer’s non-collectively bargained employees who work (in an office or elsewhere) more than 24 hours per week, and at the employer’s option, may also agree to contribute for such employees who work less than 24 hours. Non-Bargained Office Employee coverage for any or all employers may be terminated by the Trustees at any time.

2. In Article 1, under the heading “**Initial Eligibility – Dependents – All Classes**” and immediately before the heading “**Continuing Eligibility – Active Classification**”, (Page 7), the following is added:

“Opting Out of Dependent Coverage”

- “Any individual eligible for dependent coverage may opt out of such coverage by signed written notice to the Trustees, specifying the date on which such coverage will terminate. Any individual who has voluntarily terminated dependent coverage may reinstate such coverage by written notice to the Trustees, provided that the individual is eligible for dependent coverage at the time of reinstatement.”

3. In Article II, the table of benefits for “**Mental Health and Substance Abuse**”, (page 19) is revised, see below:

MENTAL HEALTH AND SUBSTANCE ABUSE*	IN NETWORK PROVIDER	NON-NETWORK PROVIDER	OUT-OF-AREA NETWORK PROVIDER
Physician’s Office <i>Individual Therapy</i> <i>Group Therapy</i>	\$20 co-payment \$10 co-payment	70% 70%	\$20 co-payment \$10 co-payment
Intensive Outpatient Treatment, Partial Hospitalization (No maximum day limitations) Residential Facilities 1,3 (Maximum 30 days per category per calendar year)	90%	70%	90%
Inpatient Mental Health and Alcohol/Substance Abuse (30 day maximum per calendar year) 1	90%	70%	90%

*Precertification by the Plan’s Mental Health Managed Care Company is required for all Mental Health and Substance Abuse Benefits, except office visits with an in-network psychiatrist or for emergency treatment. Emergency treatment does require notification to the Plan’s Mental Health Managed Care Company no later than the next business day following commencement of the emergency treatment.

- a) The maximum days per calendar year for care in Residential facilities are changed from 15 to 30 days and the maximum day limit is removed for Intensive Outpatient Treatment and Partial Hospitalization.
 - b) The \$10 co-payment for group therapy, and the \$20 co-payment for all other office visits, apply to office visits with a network provider, (psychiatric or non-physician).
 - c) All benefits are extended to non-network providers, at 70% coinsurance.
 - d) Precertification by the Plan’s Mental Health Managed Care Company is required for all Mental Health and Substance Abuse Benefits, except office visits with a network psychiatrist.
4. In Article III, under the heading “**Pre-Authorization is Required**”, the first sentence of the third paragraph (page 27) is revised to read, However, benefits are payable for emergency treatment of mental or nervous disorders or chemical and drug dependency, in case of an emergent medical condition, without advance authorization.
 5. In Article III, immediately following the heading, “**Mental Health and Substance Abuse Network**”, (page 27), the second sentence is revised to read, “The highest level of benefits is paid for treatment of mental or nervous disorders or substance abuse if such treatment is rendered by a provider in the

Mental Health Managed Care Network”, or when applicable, by an Out-of-Area Network Provider. The last sentence is revised to read, “If you get treatment from a non-network provider, the level of benefits is reduced as shown in the Schedule of Benefits.

Under the same heading, and under the subheading “**Benefits**”, under the **Partial Hospitalization** bullet point, everything following the first sentence is deleted. Under the **Intensive Outpatient Care** bullet point, the words, “and is limited to the number of days shown in the Schedule of Benefits per calendar year” are deleted from the first sentence, and the last sentence is deleted.

6. In article III, under the heading “**Covered Charges**”, item 22 (page 32), the last bullet point is revised to read as follows:
 - “Prosthetic devices for replacement of a lost body part provided the device is certified as Medically Necessary by the Medical Management Care Company. The covered charge for an electronic prosthetic device will be limited to the charge otherwise allowable for a non-electronic mechanical prosthetic device designed to replace the same natural body part. The cost of replacing a prosthetic device that is damaged or worn out and cannot be economically repaired will be considered as a covered charge only if the following additional conditions are met: The need for a replacement must not result solely from technological advancement; the patient must have a Medicare functional level assessment of 3 or greater; and the device must be obtained from a network provider”.

Effective May 1, 2008

1. In Article I, (page 7 & 8), under the heading “**Continuing Eligibility-Active Classification**”, and the subheading “**Continuing Eligibility – Outside Eligibility**”:
 - the word “250” appearing twice in the first bullet point is revised to read, “300”.
 - the word “1,000” appearing twice in the second bullet point is revised to read “1,200”.
 - and the word “1,200” appearing three times in the third bullet point is revised to read, “1,300”.
2. In Article I, under the heading “**Continuing Eligibility – Active Classification**” and the subheading “**Continuing Eligibility – Inside Eligibility**”:
 - the word “250” appearing twice in the first bullet point is revised to read, “300”.
 - the word “1,000” appearing twice in the second bullet point is revised to read, “1,200”.
3. In Article I, (page 9) under the heading, “**Reinstatement Provisions – Active Classification**”, and the subheading “**Outside and Inside Eligibility Class**”:
 - The word “250” appearing in the first paragraph once is revised to read “300”.

Effective July 1, 2008

1. **Moving Certain Drug Therapy Classes from the Carpenters’ Medicare PDP Plan (RX) to the Carpenters’ Medicare Supplement Plan (Medical)**. The plan currently covers certain oral medications and diabetic supply items under the Carpenters’ Medicare Part D-PDP Plan (Prescription Plan) that are eligible for reimbursement under Medicare Part B. By moving the coverage, Medicare Part B will be required to reconsider the charges as the primary carrier and the Carpenters’ Medicare Supplement plan would assume a secondary coverage position, thus reducing our liability.

Below is a list of medications or supplies that will be moved to the Carpenters’ Medicare Supplement Plan:

- Drugs via DME
- Immunosuppressants
- Oral Antiemetics
- Oral Antineoplastics
- Erythropoietin (EPO)
- Diabetic Supplies

Effective August 21, 2008 - (Fifth Amendment)

1. In Article I, (page 6), the second paragraph, under the heading “**Initial Eligibility-Dependents-All Classes**” is amended to read as follows:

“Subject to the provisions that follow, your ‘eligible dependents’ include your spouse and each of your unmarried children under the age of 19.”

2. In Article I, (page 6), the third paragraph under the heading “**Initial Eligibility-Dependents-All Classes**” is deleted, and the following three headings and related paragraphs are added in place of thereof:

Eligibility of Spouses

“Your ‘spouse’ is your legal partner in marriage, provided the union is by civil or religious ceremony performed in accordance with the laws applicable to the state in which you reside. For purposes of this Plan, ‘spouse’ does not include status as a common law spouse.”

“For purposes of this Plan, an individual ceases to be your ‘spouse’ upon divorce, legal separation, **annulment** or death. Eligibility and coverage of a dependent spouse end on the last day of the month in which a decree of divorce or legal separation is entered, or in which the spouse’s death occurs.”

Working Spouses of Active Members

“If you are covered under the Active classification and are married, then as a condition of your spouse’s eligibility, you and your spouse must provide information about the employment status of your spouse whenever requested by the Plan.”

“Beginning January 1, 2009, during any period when your spouse is employed and eligible to participate in a qualified employer-sponsored health plan; your spouse must be enrolled in the qualified plan of your spouse’s employer in order to be eligible for benefits in this Plan as a dependent spouse. When your spouse has complied with this requirement, the plan of your spouse’s employer will be ‘primary,’ and this Plan will be ‘secondary’ for benefits due to your spouse (see Article VIII).”

“For purposes of these working spouse rules, a ‘qualified’ employer-sponsored health plan is a plan that: (i) is insured, or self-insured by the employer and is subject to regulation by state or federal agencies such as the US Department of Labor or Internal Revenue Service; and (ii) offers industry recognized standard benefits for medically necessary hospitalization, surgery and outpatient medical treatment. In case of a choice, your spouse is required to enroll in at least single (spouse only) coverage at the standard benefit level of a qualified plan (not high-deductible or limited coverage), as well as prescription drug coverage if offered. Your spouse is not required to elect dental or vision benefits, or family coverage.”

“Your working spouse will not lose eligibility in this Plan **solely** on account of a mandatory waiting period following application for enrollment in the employer’s plan, **provided that your spouse’s application was made in time to prevent loss of eligibility.**”

Exceptions: Your working spouse is not required to enroll in an employer-sponsored plan in order to maintain eligibility in this Plan, in any of the following situations:

- If your spouse is self-employed and has no other employees.
- If your spouse only works part time (24 hours or less per week).
- If your spouse’s employer would not contribute toward the cost of your spouse’s health coverage, and would require your spouse to pay 100% of the cost.
- If the Trustees determine that due to unusual and unforeseen circumstances, enrollment by your spouse would impose an extreme hardship. So long as your spouse’s employer also contributes to the cost of coverage, the cost to your spouse will not ordinarily be deemed an extreme hardship.

“The trustees may require written verification from your spouse’s employer that any of the requirements of this Plan for maintaining working spouse eligibility have been satisfied. For example, such verification may be requested concerning the type of health coverage offered by the employer, the employer’s contribution to the cost of coverage, the date and type of coverage elected by your spouse, your spouse’s hours of employment, or other relevant facts.

“For purposes of these working spouse rules, ‘required documentation’ includes a complete response from you and your spouse to an information request from the Plan, as well as written verifications from your spouse’s employer after you have been notified that such verifications are required. Your spouse’s eligibility for benefits will be suspended until required documentation is received by the plan. When required documentation is received, it will be given retroactive effect, limited to 12 months prior to the date of receipt by the Plan.”

“**Dependent Child Eligibility**”

3. In Article I, (page 7), under the heading “**Continuing Eligibility – Outside Eligibility**,” the following is added before the last sentence under the second bullet point:

“In order for your eligibility to continue under this provision, you must be eligible for employment with a contractor who is signatory to a labor contract with the Carpenters’ District Council of Greater St Louis and Vicinity or must be eligible to be employed by the Carpenters’ District Council or the Carpenters’ Benefit Fund Office.”

4. In Article I, (page 11), the following new heading and paragraph are added immediately before the heading “**Working under the Non-Active Classification**”:

“**Union Affiliation of Non-Active Members**”

“As a condition of eligibility for benefits under the Non-Active classification, all non-active members (except Surviving Spouses and Retired employees of the Carpenters’ Benefit Fund Office), including retired, retired self-employed, Non-Pension and disabled members, must maintain membership in the Carpenters’ District Council or its affiliated Locals at all times while not working in covered employment.

Effective January 1, 2009

1. In Article III, (page 23), the following new heading and related paragraphs are inserted immediately before the heading “**Managed Care**”:

Special Voluntary Orthopedic Program

“The plan has contracted with Signature Health Services, Inc., a CMR network provider, to offer to you and your eligible dependents a complete course of treatment of certain specialized orthopedic conditions. The Plan believes that the treatment protocol for these conditions developed by Signature Health’s physicians is likely to provide better than average outcomes and reduced recovery time. The procedures currently included in this program are:

- Total Knee Replacement
- Rotator Cuff Repair

“Other procedures may be added to the program. If you select Signature Health physicians to provide a procedure covered in the program, and if you complete the entire course of treatment recommended by Signature Health, from diagnosis through education, surgery, and post-operative therapy, then upon certification of completion from Signature Health, the Plan will rebate \$150 to you to offset your out-of-pocket expenses.

“Participation in this special program is entirely voluntary. For more information, and instructions on how to enroll in the program at Signature Health, please contact the Benefit Fund office.”

2. In Article III, (page 24), under the heading “**Managed Care**”_ and the subheading “**Generally**,” in the first paragraph following the bullet points, the last sentence is amended to read:

“**Failure to comply may result in reduced benefits or loss of all benefits.**”

3. In Article III, (page 26), under the heading “**How Your Benefits are Affected**”, the first paragraph is deleted and the following is inserted in place thereof:

“If you receive care from an In-Network provider, it is the provider’s responsibility to contact the Medical Care Management Company when required by the Plan, and your benefits will not be affected if the provider fails to do so. However, if you receive care from a Non-Network provider or an Out-of-Area Network provider, it is your responsibility to contact the Medicare

Care Management Company when required by the Plan, and your benefits may be affected as described below.”

“If you call the Medical Care Management Company when required by the Plan, and it is determined that your treatment or procedure is not medically necessary, no benefits will be payable for that treatment or procedure.”

“If you fail to call the Medicare Care Management Company when required by the Plan, it is presumed that the treatment or procedure is not medically necessary, and therefore that no benefits are payable. In such a case, after receiving your claim, the Plan will notify you that the claim will be denied unless you provide the Plan within 45 days with information sufficient to demonstrate that the treatment or procedure was medically necessary. If you provide an adequate demonstration of medical necessity, after having failed to comply with the Managed Care procedures, your benefits will be reduced as follows:”

4. In Article III, (page 26), under the heading “**How Your Benefits are Affected**”, the second sentence of the “**NOTE**” is amended to read:

“However, if you fail to obtain a determination of medical necessity by calling the Medical Care Management Company when required by the foregoing Managed Care provisions, and you do not provide sufficient timely information to enable the Plan to determine that your treatment or procedure was medically necessary, no benefits will be paid.”

5. In Article VIII, (page 45), in the last paragraph under the heading “**Generally**”, the following is added after the third sentence:

“However, in all cases submit your claim to this Plan before expiration of the one year time limit (see page 49), even if there are later, related claims or a delay in processing by the primary plan.”

6. In Article X, under the heading “**Medical, Dental, and Prescription Drug Claims**” and the subheading “**How Benefits Will Be Paid**”, the second and third paragraphs are deleted and replaced by the following:

“Benefits are not assignable, and any purported assignment of benefits to a provider or other person is void and confers no right to pursue a claim or appeal against the Plan. The Plan does not confer rights on any third party beneficiary. You, as a covered individual, are the only person legally entitled to receive payment of benefits from the Plan. However, the Plan may in its discretion pay benefits on your behalf directly to a provider of covered services, drugs or supplies, and any such payment will discharge the obligation of the Plan to pay the same benefits to you. If the Plan elects to make payments directly to providers, the Plan reserves the right to allocate the deductible amount among eligible charges and to apportion the benefits paid to each provider accordingly. The plan will not pay any “hospital surcharge” such as those imposed by the states of Massachusetts and New York.

7. In Article X, (page 50), under the heading “**Miscellaneous Provisions Pertaining to Claims and Appeals**”, the following is added to the end of the first paragraph:

“A person designated by any means other than the Plan’s approved form, or a document satisfying the requirements of a durable power of attorney for health care under the laws of Missouri, may not act as your authorized representative in pursuing a claim or appeal, with the following exceptions: Your spouse or your court-appointed guardian or conservator may act as your authorized representative; a parent may act as the authorized representative of an eligible dependent child; and a licensed health care professional with knowledge of your medical condition may act as your authorized representative in case of an urgent care claim.”

8. In Article XI, (page 60), under the heading “**Board of Trustees**”, the following paragraph is added to the end, before the next heading:

“The Trustees may debar a provider of services or supplies, if the Trustees determine in their discretion that the provider has (i) submitted false or fraudulent claims; or (ii) failed to comply with the terms of its contract with a network engaged by the Fund; or (iii) repeatedly submitted claims in a manner that results in harassment or unreasonable administrative effort in processing by the Fund. No benefits will be due or paid for services or supplies obtained from a debarred provider during the period of debarment.”

In Appendix B, (page 73), under the heading “**The Covered Person’s Duty to Cooperate with the Plan**”, the following is added to the end of the first paragraph:

“If the covered person or attorney fails to sign and deliver an agreement requested by the Plan within a reasonable time (not to exceed one year), the Trustees may withdraw their offer to advance benefits and decline to advance any benefits before the liability of the third party has been determined.”

9. In Article III, the following sentence is added at the end of the third paragraph under the heading, “**Preventive Care**”. (Page 23):

“Physician office charges incurred for a dependent child during the first 24 months of life under CPT codes 99381, 99382 and 99392 will not be counted against the maximum annual benefit for such dependent.”

Effective February 19, 2009

1. In Article I, the following is added as a new third paragraph under the heading “**Working Spouses of Active Members**”:

“The Benefit Plan Administrator is authorized to terminate eligibility of a dependent spouse for benefits from this Plan if necessary to enable the spouse to enroll in the plan of the spouse’s employer, and to reinstate eligibility in this Plan after the spouse has enrolled in the plan of the spouse’s employer.”

Effective January 1, 2010

1. In Article II, the following changes are adopted in the Schedule of Benefits:

- a) In each case where the Coinsurance rate for a Non-Network Provider is shown at 70%, the rate is amended to read “50%” except as follows: Under the heading “**BENEFIT**,” the coinsurance rate for Non-Network Provider is amended to read “50%” unless otherwise specified.” Under the heading of “**INPATIENT SERVICES**,” a benefit is added for “Emergency care rendered during an inpatient hospital visit,” with coinsurance rates of 100% for In Network Provider, 70% for Non-Network Provider, and 90% for Out-of-Area Network Provider. In an Urgent Care Facility, the coinsurance rate for a Non-Network Provider is amended to read “70% for emergency care, otherwise 50%.
- b) Under the heading “**BENEFIT**,” the Individual Out-of-Pocket Maximum for Non-Network Provider is amended to read “\$3,000 for emergency care rendered during an inpatient hospital visit or in an Urgent Care facility; otherwise no limit.”
- c) Under the heading “**OUTPATIENT SERVICES**,” a benefit is added for “Observation Services, except on account of pregnancy” with \$100 co-pay per visit (In-Patient Co-pay applies if admitted) for In Network Provider; 50% coinsurance for Non-Network Provider; and \$200 co-pay per visit (In-Patient Co-pay applies if admitted) for Out-of-Area Network Provider.
- d) The second sentence of Footnote 1 is deleted.
- e) The separate schedule of benefits beginning with the heading “**MENTAL HEALTH AND SUBSTANCE ABUSE**” is deleted.

2. In Article III, the following changes are adopted in the benefit table under the heading “**Prescription Drug Co-Payments**” (p.29) and the benefit table under the heading “Prescription Drug” (p.35):

- a) For Single Source Brand, “You Pay: Retail” and “You Pay: Mail” are amended to read “35%.”
- b) The Maximum Co-Pay Per Script is amended to read “\$75” for up to 30-day supply, and “\$150” for 31-90 day supply.
- c) The footnote beginning with a single asterisk is deleted.

3. In Article III, under the heading “**OUT-OF-AREA NETWORK AND NON-NETWORK BENEFIT LEVEL**” (p.20), the third sentence is amended to read as follows:

“After the deductible is satisfied, the Plan pays its coinsurance (generally 90% for Out-of-Area Network Providers and 50% for Non-Network Providers except as otherwise stated in the Schedule of Benefits), and you pay yours (generally 10% for Out-of-Area Network Providers, and 50% for Non-Network Providers).”

4. In Article III, under the heading “**Out-of-Pocket Maximum**” (p.21), the third paragraph is deleted.
5. In Article III, under the heading “**Out-of-Pocket Maximum**” (p.21), the next to last bullet point is amended to read as follows:

“Non-Network charges, except charges for emergency care rendered during an inpatient hospital visit or at an Urgent Care Facility.”
6. In Appendix G, under the heading “**PRESCRIPTION DRUG PLAN**” (p.89), the footnote beginning with a single asterisk is deleted, and the two bullet points in the paragraph headed “Brand Name Drugs **without** Generic Equivalent available,” and the two bullet points in the paragraph headed “Brand Name Drugs **with** Generic Equivalent available,” are amended to read as follows:
 - “Up to 30-day supply: 35% (\$75 co-payment maximum per prescription)”
 - “31-90 day supply: 35% (\$150 co-payment maximum per prescription)”
7. In Article III, under the heading “**IN-NETWORK BENEFIT LEVEL**” (p.20), the second sentence is amended to read as follows:

“After a small co-payment for some services, the Plan pays 100% of most covered expenses.”
8. In Article III, under the heading “**How Your Benefits are Affected**” (p.26):
 - a) Wherever the words “Medical Care Management Company” appear, the words “or Mental Health Managed Care Company, as appropriate,” are inserted immediately following.
 - b) In the sixth paragraph, the words “or before receiving treatment for mental and nervous disorders and chemical and drug dependency,” are inserted after the words “ancillary procedure specified in a previous section.”
 - c) The “**NOTE**” is amended to read as follows:

“Your benefits otherwise payable for any one confinement, procedure or ancillary service will not be reduced more than \$1,000 solely because of your failure to call the Medical Care Management Company or Mental Health Managed Care Company when required by the foregoing Managed Care provisions. However, if you fail to get an advance determination of medical necessity by calling the appropriate Company when required by the foregoing Managed Care provisions, and you do not provide sufficient timely information to enable the Plan to determine that your treatment or procedure was medically necessary, no benefits will be paid.”
9. In Article III, under the heading “**Ambulatory (Outpatient) Procedures and Ancillary Services Review**” (p.25), the statement “You must also contact the Medical Care Management Company before any of the following ancillary services or supplies are provided” is amended to read, “You must also contact the Medical Care Management Company or Mental Health Managed Care Company, as applicable, before any of the following ancillary services or supplies are provided,” and the following three bullet points are added following this statement:
 - Partial hospitalization for treatment for mental and nervous disorders, alcoholism and substance abuse.
 - Intensive outpatient care for treatment of mental and nervous disorders, alcoholism and substance abuse.
 - Residential care for treatment of mental and nervous disorders, alcoholism and substance abuse
10. In Article III, under the heading “**Mental or Nervous Disorders/Chemical and Drug Dependency**” (p.26):
 - a) Under the subheading “**PRE-AUTHORIZATION IS REQUIRED**” (p.26), the shaded box and its contents are deleted; the first sentence of the third paragraph (p.27) is amended to read: “Advance authorization is not required for emergency treatment of mental or nervous disorders or chemical and drug dependency”; and the words “in order to qualify for benefits” are deleted from the end of the fourth paragraph.
 - b) Under the subheading “**MENTAL HEALTH AND SUBSTANCE ABUSE NETWORK**” (p.27), the second sentence and the last sentence are deleted from the first paragraph; and all provisions following the first paragraph are deleted, up to the subheading “**MEMBER ASSISTANCE PROGRAM (MAP)**.” (p.28).

11. In Article III, the heading “**How Your Benefits are Affected**” and all provisions under that heading, through the “**NOTE**” (p.26) are moved and reinserted immediately before the heading “**MEMBER ASSISTANCE PROGRAM (MAP)**” (p.28).
12. In Article I, under the heading “**WORKING SPOUSES OF ACTIVE MEMBERS**” (added by the Fifth Amendment (page 4 of this document):
 - a) The following is added to the end of the second paragraph: “If your spouse fails to become enrolled in an employer-sponsored health plan when required, or fails to complete the information form requested by the Plan, your spouse’s eligibility for benefits in this Plan will be suspended. If your spouse thereafter enrolls in the spouse’s employer-sponsored health plan, or completes the required form, your spouse’s eligibility in this Plan will be reinstated at the date of such enrollment, but not retroactively.
 - b) The following new paragraph is added immediately before the heading “**DEPENDENT CHILD ELIGIBILITY**”:

“If your working spouse is enrolled in an employer-sponsored health plan, and if the Trustees of this Plan determine that it would be in the interest of this Plan to do so, this Plan may offer to pay the premium that your spouse would otherwise pay to enroll any of your dependent children in your spouse’s health plan.”
13. In Article I, under the heading “**DEPENDENT CHILD ELIGIBILITY**” (Heading added by the Fifth Amendment), the following is added to the end of the first bullet point paragraph (p.6):

“A child otherwise eligible will be considered to remain in full-time status for up to one year during any leave of absence or reduction in credit hours that would otherwise cause a loss of eligibility, provided that the leave of absence or reduction in hours is medically necessary on account of a serious illness or injury and begins while the child is eligible for dependent coverage as a student and is suffering from the serious illness or injury, and provided that the Plan receives written certification from the child’s treating physician that the child is suffering from a serious illness or injury that makes the leave or reduction medically necessary.”
14. In Article III, under the heading “**COVERED CHARGES**” (p.30), paragraph 7 is amended to read: “Charges for treatment of mental or nervous conditions, or chemical or substance abuse.”