North Atlantic States Carpenters
Benefit Funds

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# SUMMARY MATERIAL MODIFICATIONS

Dear Plan Participant:

On behalf of the North Atlantic States Carpenters Health Benefits Fund, you are receiving this notice to inform you of important upcoming Health Fund changes to the New York Hours based plan.

## WORK PERIOD CHANGES

**Transition Work Period effective 7/1/23 – 1/31/24**
**Fully effective for work period 2/1/24 – 7/31/25 and thereafter**

The Board of Trustees has authorized shortening the time period between the end of a Work Period and the start of the associated Insured Period. This is largely due to efficiencies made in reciprocal turn around with other UBC funds, diligent collection efforts for delayed remittances and to bring parity with the other areas within North Atlantic States Regional Council of Carpenters.

Below is a chart that details the transition to the new Work Periods. It is important to note the transition Work Period of July 1, 2023, through January 31, 2024 is a seven (7) month period which will benefit Participants by giving them an extra month to meet the work hours eligibility requirements the April 1, 2024 Insured Period.

| | **Insured Period April 1 through September 30** | | **Insured Period October 1 through March 31** | **Insured Period April 1 through September 30** |
|---|---|---|---|---|
| **Local 279, 290 and Hours Based Local 291 and Hours Based 1163** | Work Period: **July 1, 2023 – January 31, 2024*** ***transition period** | | Work Period: **February 1, 2024 – July 31, 2024** | Work Period: **August 1, 2024 – January 31, 2025** |
| *Eligibility for 4/1/24 – 9/30/24 - This one-time transition period will be based on hours worked during an extended work period of 7/1/23 – 1/31/24 as a transition to the new work periods. | | | | |

## ELIGIBILITY HOURS REQUIREMENT CHANGES and New Plan II

**Effective February 1, 2024, Work Period for Coverage Effective October 1, 2024**

The Board of Trustees regularly reviews the relationship between ongoing plan costs and hours being contributed with the goal of ensuring the solvency of the Health Plan is protected. After review of the current plan design, the Trustees voted to implement a Plan II which requires less hours worked during a Work Period to achieve health coverage. By doing so, this will allow Participants to earn health coverage who otherwise would not have been eligible. The Hours requirements for Plan I and the NEW Plan II are reflected below: More information on the NEW Plan II medical plan design in on page 5 of this document.

| | PLAN I | PLAN II** | Plan I 12-MONTH LOOK BACK |
|---|---|---|---|
| **Local 279 and 290** | Current: 600 Hours<br>**New: No change** | **New: 450 Hours** | **Current: 1,200 Hours**<br>***10/1/24 and Thereafter: 1,250 hours** |
| **Hours Based Local 291 and Hours Based Local 1163** | Current: 600 Hours<br>**New: 710 Hours** | **New: 530 Hours** | **Current: 1,200 Hours**<br>***10/1/24: 1,360**<br>**Thereafter: 1,470 Hours** |

**Eligibility for 4/1/24 will be based on current hours requirements for Plan I and the new Plan II hours requirements.**

* Eligibility for 10/1/24 will be based on new hours requirements and a blend of old and new for the 12 Month Look Back.

Eligibility for 4/1/25 and thereafter will be based on the new hours requirements.

** Details on Plan II benefits and changes to Plan I are described later in this SMM.

## ADDITIONAL ELIGIBILITY PROVISIONS

**Effective for April 1, 2024, Insured Period**

### 12-Month Look Back

Participants who have not worked enough hours during the most recent work period to maintain coverage in Plan I will be able to utilize hours worked in the current and previous work periods, plus an additional 50 hours, to maintain Plan I eligibility through the next Insured Period.

> **Example:** A Local 279 Participant worked 500 hours February 1 – July 31, eligibility for October – March, is not earned. Participant worked 800 hours in the previous work period of August 1 – January 31 for a total of 1300 hours worked in two consecutive work periods. 12 Month Look Back requires 1250 hours (600 + 600 + 50), so this Participant will be able to maintain Plan I coverage for the Insured Period October 1 – March 31.

### Short Hour Buy-In

If you do not work enough hours during a work period to obtain or maintain your eligibility, you may purchase Buy-In coverage if you are short by 50 hours or less. You are eligible to purchase the Short Hour Buy-In regardless of whether you had coverage or not in the preceding period. You may have consecutive Short Hour Buy-In periods. **This provision will replace all previous self-pay provisions for eligibility on April 1, 2024, and thereafter.**

### Aggregated Hours Provision

The Board of Trustees has adopted a rule that allows legally married couples the ability to aggregate their hours to secure health eligibility if they cannot obtain eligibility individually based on the hours they each worked. If your hours are combined and you still do not secure coverage but are within the Short Hour Buy-In provision threshold, you will be offered this option or if you are eligible for the 12-Month Lookback, the rule will be applied to determine your eligibility. Your hours cannot be aggregated to achieve a greater plan of benefits. For example, if one of you works enough hours to achieve eligibility for Plan II, you then cannot aggregate your hours to receive coverage under Plan I. To take advantage of this rule you must apply at each insured period, when necessary, by contacting the Fund Office. You and your spouse will be required to complete a form requesting that your hours be aggregated, and the request must be made prior to the Insured Period.

### Worked Hours Credit Rule

This provision allows for a worked hours credit to be applied to reduce the cost of COBRA or the Retiree Health Plan as of April 1, 2024.

### New Participants

A new Participant will be defined as having no hours worked and coverage under Plan I, Plan II, or COBRA for two consecutive years. For initial eligibility purposes as of April 1, 2024, coverage starts the first of the following month in which the contributions for the hours required for Plan II are received by the Fund Office.

### Apprentice Training Credit

Effective April 1, 2024, New York hours based apprentices attending school at the Apprentice Training Center who do not work enough hours during a work period can apply for Apprentice Training Credit. Apprentices can be credited with 40 hours or less for one week of school or 80 hours or less for two weeks of school, in a work period. Apprentice Training Credit can also be applied toward Short Hour Buy-In, COBRA, or the 12 Month Look Back rule as well as to gain initial eligibility under the Plan. Credit will only be granted if hours are needed to gain or maintain health coverage with supporting documentation of attendance provided by the Apprentice Training Center.

### Benefits for a Surviving Spouse and Dependents of Deceased Participants

If a Participant dies during an Insured Period, coverage for the surviving spouse and covered eligible dependents will continue until the Insured Period ends through worked hours, including Disability Extensions and Short Hour Buy-Ins. At that time the Fund will provide continuing coverage for the surviving spouse and eligible dependents for thirty-six (36) months at no cost. Coverage will continue in either Plan I or Plan II depending on what the Participant's coverage was at the time of death. The surviving spouse and dependent(s) must attest that they have no other health insurance available to them to qualify for this benefit. If a Participant's health coverage was suspended because there were four (4) consecutive months with no hours contributed on his behalf or while not in good standing with their Local Union, the surviving spouse and otherwise eligible dependent(s) will receive the thirty-six (36) months of coverage as stated above. This extension will be offered to surviving spouses and otherwise eligible dependent(s) of a Participant who passes away on or after April 1, 2024.

### Active Coverage Extension at Retirement

A retired Participant will be able to remain on Plan I or Plan II until their earned active coverage is exhausted. This includes utilizing the 12-Month Look Back Rule. After active coverage ends, the retired Participant may be able to enroll in the Retiree Health Plan (Plan III) as a retiree or the Health Fund sponsored Medicare Advantage Plan if you are Medicare age. This provision will replace all previous rules for continued eligibility on April 1, 2024. Previous active coverage extension have been eliminated as of April 1, 2024.

## DISABILITY TIME LOSS BENEFITS CHANGES
**Effective April 1, 2024**

### Illness and Non Work-Related Injuries

The Disability Time Loss benefit has largely been unchanged for years. The benefit payment amount was recently reviewed by the Board of Trustees, and it was decided to increase the benefit amount for those Participants who find themselves sick or injured and unable to work. The Board of Trustees is also introducing Disability Extensions to assist Participants in maintaining their health coverage while they are disabled.

| | Length of Time | Benefit Amount | Hours Credited |
|---|---|---|---|
| **Local 279 and 290** | Current: 52 weeks<br>**New: Up to 26 weeks** | Current: $170 per week<br>**New: $330 per week** | Current: Up to 30 hours per week<br>**New: Up to 40 hours per week** |
| **Hours Based Local 291 and Hours Based Local 1163** | Current: 52 weeks<br>**New: Up to 26 weeks** | Current: $50 per week<br>**New: $330 per week** | Current: Up to 30 hours per week<br>**New: Up to 40 hours per week** |

A Participant must have health coverage to be eligible to receive this benefit at the time of illness or nonwork-related injury and collecting New York Stare Disability benefits to be eligible for benefit payments under the Disability Time Loss Benefit.

Participants receiving Worker's Compensation benefits as of April 1, 2024, are not eligible for benefit payments through the Disability Time Loss Benefit.

### Paid Family Medical Leave / Disability Time Loss / Worker's Compensation Hours Credit

Participants who are eligible for coverage under the Health Plan at the time of their illness, injury or Paid Family Medical Leave period will be credited with up to 40 hours per week for a maximum of 26 weeks. Crediting these disability hours will allow Participants the ability to achieve health coverage for future Insured Periods for which they may not have been eligible had the disability hours not been credited. These disability hours will be treated as if they were actual hours worked and will be applied towards the 12-Month Lookback and Short Hour Buy-in provisions of the Plan. To be eligible, you must provide proof of New York State Disability, New York State Paid Family Medical Leave or Worker's Compensation benefits to the Health Fund. Credit will be provided for incidents occurring on or after April 1, 2024.

### Disability Health Coverage Extension

If a Participant is injured or becomes ill while covered under the Health Plan and as a result of that disability does not have enough hours to maintain or qualify for initial eligibility for the following Insured Period the Participant will qualify for a disability health coverage extension that extends coverage for the next Insured Period. A Participant may utilize two disability extensions in their career. They may be used consecutively with one continuing disability or on separate occasions. Participants must be collecting New York State Disability benefits to be eligible for the Disability Extensions. Extensions will be available for incidents that occur on or after April 1, 2024.

### Successive Periods of Disability

Successive periods of disability separated by less than two weeks of continuous employment are considered one period of disability. If a Participant suffers another unrelated disability, a Participant must have returned to active work for a period of more than two weeks to receive a benefit for a separate period of disability.

## MEDICAL PLAN CHANGES FOR ACTIVE PARTICIPANTS
**Effective April 1, 2024**

In an effort to provide health coverage to more Participants, the Board of Trustees has implemented another level of health coverage called Plan II. This plan will provide coverage for those who did not reach the Plan I hours requirement.

Below details Plan II and summarizes benefit changes to Plan I, previously referred to as the Active Plan of benefits. In general, with these changes to Plan I you will share more of the cost when you receive services; however, you will find that our coverage still compares very well to other plans available.

Most significantly, many services previously covered at 100% will now be subject to deductibles and co-insurance.

**Effective April 1, 2024**

| | PLAN I | | PLAN II | |
|---|---|---|---|---|
| | **In Network** | **Out of Network** | **In Network** | **Out of Network** |
| **DEDUCTIBLE** | Current: $0 individual, $0 family<br><br>**New: $300 individual, $600 family** | Current: $200 individual and $200 family<br><br>**New: $300 individual, $600 family** | **New: $500 individual, $1,000 family** | |
| **COPAY** | Current: $20 regular and specialist office visit<br><br>**New: $15 regular office visit**<br>**New: $30 specialist office visit** | Current: None<br><br>**New**: **None** | **New: $20 regular office visit**<br><br>**New: $40 specialist office visit** | **New**: **None** |
| **CO-INSURANCE** | **Current: 0%**<br><br>**New: 20% after deductible** | Current: 100% of the balance after allowable rate is paid<br><br>**New: 25% after deductible** | **New: 30% after deductible** | **New: 40% after deductible** |
| **OUT OF POCKET MAXIMUM** | Current: $3,000 individual, $6,000 family<br><br>**New: $2,000 individual, $4,000 family** | Current: $3,000 individual, $6,000 family<br><br>**New: $3,200 individual, $6,400 family** | **New: $3,200 individual 6,400 family** | **New: $4,300 individual $8,600 family** |

### Out of Pocket Maximum

The calculation of out of pocket maximums is changing to a calendar year effective January 1, 2024. In order to accommodate the change from an April 1 renewal date to January 1 renewal date, the Fund will use what was accumulated from January 1, 2024 through March 31, 2024 towards your 2024 individual and family out of pocket maximum. Additionally, Participants who have reached the previous individual and/or family out of pocket maximum on as of December 31, 2023, will not need to meet their out of pocket maximum for 2024.

**Out of Network Allowable Rate**

As of April 1,2024, the out of network rate of reimbursement will be 150% of the Medicare allowance for each service performed by an out of network provider. The Participant will be responsible for any balance billing related to out of network services.

**Coinsurance**

Coinsurance is the percentage of cost of a covered medical service that a Participant is responsible for after paying any applicable annual deductible and copay. For example, assuming a Participant's deductible has been paid, the following details the effect of coinsurance: An MRI costs $2500, the contracted allowable amount under in network insurance is $1800, provided the participant has not reached the Out of Pocket maximum, the Participant is responsible for 20% of the allowable amount ($1800) which is $360, that is the coinsurance. The Plan will pay the $1440 balance of the allowable amount.

**Diagnostic Laboratory and Diagnostic Services**

These medical services will be subject to the 20% coinsurance. They include but are limited to out-patient diagnostic and X-ray services; out-patient hospital/facility services; and CT scans and MRI's, after the deductible has been satisfied.

**Preventative Care – Paid at 100%**

Services provided annually that are considered Preventative Care such as physicals for adults and children, mammograms, eligible colonoscopies will be paid at 100% and in-network services are not subject to deductible. Preventative care visits are important for everyone but can also assist in early detection and for certain tests create baselines that can be used later to determine abnormalities in the future.

## DENTAL BENEFITS
**Effective April 1, 2024**

Your dental coverage administered by Delta Dental will now be included as part of your Plan I and Plan II medical coverage. If your Delta Dental premium is deducted from your HRA, your last premium payment will be deducted in February 2024 for March 2024 coverage. Benefits through Delta Dental will not change and you will be able to use your current ID card. If you were not previously enrolled in Delta Dental but are covered under Plan I or Plan II on April 1, 2024 you will receive an ID card and benefit summary in March 2024. Your new dental coverage will be effective April 1, 2024.

## NEW VIRTUAL CARE PROVIDER - TELEDOC
**Effective January 1, 2024**

Independence Administrators is enhancing virtual care benefits offered to Participants by moving to a new provider, Teledoc. Teledoc's network of providers is amongst the largest in the nation making access to virtual care even easier. The new benefits are available 24/7 and will be replacing the current MDLIVE virtual care provider. There will be a regular office copay according to your Plan for Teledoc services, the same as a regular office copay. Please see the attached flyer outlining the new Teledoc program.

## NON-MEDICARE RETIREE HEALTH ELIGIBILITY CHANGES
**Effective April 1, 2024**

Providing retiree health coverage is very challenging for any organization, and our Health Plan is no exception. After a lengthy discussion regarding current subsidies, the current financial condition of the Health Plan, and equity among all Participants, the Board of Trustees has made the following changes:

**Non-Medicare Retiree Eligibility Requirements**
A Participant will be offered the Non-Medicare Retiree Health Plan upon fulfillment of the below requirements.

- Must be collecting a Pension from the North Atlantic States Carpenters Pension Fund
- A dues paying member in good standing with a Local Union within North Atlantic States Carpenters Regional Council of Carpenters*
- Eligible for health coverage under the North Atlantic States Carpenters Heath Plan for the Insured Period immediately preceding your retirement effective date.
- Must have at least 25,000 hours contributed to the North Atlantic States Carpenters Pension Fund in their career

*Exception for Participants who are not Local Union members but are working for affiliates of the United Brotherhood under a Participation Agreement such as staff of Local Union, Training Fund, Regional Council and Benefit Fund

**Determining the Non-Medicare Premium Annually**
The Board of Trustees enlists actuaries to determine the monthly premium that Non-Medicare Retirees will pay for coverage on an annual basis. Typically, the premium is calculated, presented and approved by the Board of Trustees every January to be effective that April 1. It is important to note that the actuaries take the claims experience from all Participants, both Actives and Non-Medicare Retirees to determine these monthly premiums. This results in an already subsidized premium for Non-Medicare Retirees as a retiree population's healthcare costs are typically higher than an active population. The subsidy amounts discussed below are in addition to this general subsidy that is included at the commencement of the annual premium calculation.

**Non-Medicare Retiree Plan- Monthly premium and length of time coverage is available**
The number of hours worked with contributions made to the North Atlantic States Carpenters Pension Fund in a Participant's career will determine the percentage of the Participant's monthly premium that will be subsidized by the Health Fund.

If a Participant works…

- 50,000 or more hours in their career their premium will receive the highest subsidy available which is 25%. They will be offered up to thirty-six (36) months of coverage under the Non-Medicare Retiree Plan or until they become eligible for Medicare, whichever occurs first.
- Between 25,000 and 49,999 hours the premium will receive a subsidy of 10%. Participants will be offered up to thirty-six (36) months of coverage under the Non-Medicare Retiree Plan or until they become eligible for Medicare, whichever happens first.

This thirty-six (36) month period starts on April 1, 2024 for retirees with existing Non-Medicare Retiree coverage and a pension effective date prior to April 1, 2024.

The thirty-six (36) month period will also start when a Participant elects the Non-Medicare Retiree coverage after April 1, 2024. For example, if a Participant retires and starts their pension on January 1, 2024, but maintains active coverage through worked hours through September 30, 2024, the thirty-six (36) month period would start on October 1, 2024 when the Non-Medicare Retiree coverage is elected.

**Opt Out Provision**
If you are offered the Non-Medicare Retiree coverage, you can opt out if you are covered by another employer sponsored health plan that provides creditable coverage as determined by The Affordable Care Act of 2010.

A Participant may also opt back into the Health Plan one time if they experience a termination of their other employer sponsored creditable coverage. They will be required to submit proof that they had continuous creditable coverage for the entire time while utilizing the opt out provision. Coverage by non-employer sponsored plan irrevocably forfeits coverage under the Health Plan.

## NON-MEDICARE RETIREE HEALTH COVERAGE CHANGES

The Board of Trustees has determined that all Participants on the Non-Medicare Retirees benefits will be enrolled into the following Retiree Health Plan (Plan III). These benefits will become effective as of April 1, 2024.

| | CURRENT PLAN | | PLAN III | |
|---|---|---|---|---|
| | **In Network** | **Out of Network** | **In Network** | **Out of Network** |
| **DEDUCTIBLE** | Current: $200 individual and $200 family | Current: $300 individual and $600 family | **New: $350 individual, $750 family** | |
| **COPAY** | Current: $25 regular and specialist visit copay | **Not Applicable** | **New: $15 regular and specialist visit copay**<br>**New: $250 copay on inpatient/outpatient surgery** | **Not Applicable** |
| **CO-INSURANCE** | Current: 10% after deductible | Current: 100% of the balance after allowable rate is paid | **New: 20% after deductible** | **New: 20% after deductible** |
| **OUT OF POCKET MAXIMUM** | Current: $3,000 individual, $6,000 family | Current: $3,000 individual, $6,000 family | **New: $3,000 individual $6,000 family** | **New: $3,000 individual $6,000 family** |

**Coinsurance**

Coinsurance is the percentage of cost of a covered medical service that a Participant is responsible for after paying any applicable annual deductible and copay. For example, assuming a Participant's deductible has been paid, the following details the effect of coinsurance: An MRI costs $2500, the contracted allowable amount under in network insurance is $1800, the Participant is responsible for 20% of the allowable amount ($1800) which is $360, that is the coinsurance. The Plan will pay the $1440 balance of the allowable amount.

## PRESCRIPTION DRUG CHANGES 2024
**Effective for Plans I, II and III April 1, 2024**

In an effort to absorb the increasingly high cost of specialty drugs across the Plan, the Board of Trustees approved the following changes for **Plan I, Plan II and Plan III**:

| CURRENT PLAN | | |
|---|---|---|
| **Type** | **Retail** | **Home Delivery** |
| GENERIC | $5 copay<br>30 day supply | $10 copay<br>90 day supply |
| FORMULARY | 20%<br>coinsurance | 20%<br>coinsurance |
| NON-FORMULARY | 20%<br>coinsurance | 20%<br>coinsurance |

| NEW PLAN | | |
|---|---|---|
| **Type** | **Retail** | **Home Delivery** |
| GENERIC | $8 copay<br>30 day supply | $16 copay<br>90 day supply |
| FORMULARY | 30% coinsurance<br>$25 Min<br>$50 Max | 30% coinsurance<br>$63 Min<br>$125 Max |
| NON-FORMULARY | 30% coinsurance<br>$40 Min<br>$80 Max | 30% coinsurance<br>$100 Min<br>$200 Max |

| CURRENT PLAN | | |
|---|---|---|
| **Specialty** | | |
| **Type** | **Retail** | **Home Delivery** |
| SPECIALTY | 20%<br>coinsurance | 20%<br>coinsurance |

| NEW PLAN | | |
|---|---|---|
| **Specialty** | | |
| **Type** | **Retail** | **Home Delivery** |
| SPECIALTY | 30%<br>coinsurance<br>$150 Min<br>$300 Max | 30%<br>coinsurance<br>$150 Min<br>$300 Max |

| CURRENT PLAN | | |
|---|---|---|
| **Cost Sharing** | | |
| **Type** | **Individual** | **Family** |
| OUT OF POCKET MAXIMUM | $5,000 | $10,000 |
| DEDUCTIBLE | NONE | NONE |

| NEW PLAN | | |
|---|---|---|
| **Cost Sharing** | | |
| **Type** | **Individual** | **Family** |
| OUT OF POCKET MAXIMUM | $3,600 | $7,200 |
| DEDUCTIBLE | NONE | NONE |

**Prescription Coinsurance Minimums and Maximums**
Prescription Coinsurance is the percentage a Participant pays for a covered prescription. Under this plan the coinsurance will be at least the minimum stated above, but will not exceed the maximum stated above.

**Coinsurance Minimum Example** – a formulary brand drug costs $40, the 30% coinsurance is $12, because the Plan has a minimum coinsurance the Participant pays $25, the Plan pays the $15balance of the cost of the formulary brand drug.

**Coinsurance Maximum Example** – a formulary brand drug costs $1200, the 30% coinsurance is $360, because the plan has a maximum coinsurance the Participant will pay $50in coinsurance, the Health Fund will pay the $1,150 balance for the formulary brand drug.

**If a drug costs less than the minimum coinsurance amount, the Participant will pay the prescription drug cost amount.**

**IMPORTANT: Generic drugs are not subject to coinsurance**

**An $8 copay is all a Participant will pay for up to a 30 day supply of a generic drug. There is even greater savings if a Participant utilizes mail order. The copay for up to a 90 day supply for a mail order generic drug is $16. The Fund's CVS Smart 90 program allows for the same mail order benefits available at CVS pharmacies.**

## MEDICARE RETIREES

Medicare Retirees are currently offered a Blue Medicare PPO Advantage Plan sponsored by the Level Health Consortium. The medical and prescription monthly premium is adjusted annually and will be subject to an administrative fee. The Fund will be collecting the monthly premiums, or you can have the monthly premium deducted from your pension. This plan is not subsidized by the Health Fund. **To be eligible for the plan, you must be a dues-paying member in good standing and you must be receiving a pension from the North Atlantic States Carpenters Pension Fund**.

## MAINTAINING ACTIVE HEALTH COVERAGE

A previous Summary Material Modification in May 2023 advised you on new rules regarding maintaining active health coverage whereas Participants who do not work for a contributing employer **or** who are not available to work for four (4) consecutive months will not be eligible for coverage and will have their health coverage and HRA under the Plan suspended. Current exceptions to this rule have been updated. All exceptions include if you are retired, disabled and on New York State Disability, on Family Medical Leave including Paid Family Medical Leave, on Worker's Compensation, serving in the Military, or working for a contributing employer in a non-covered position. Lastly, if a Participant dies while in suspended status, Life Insurance benefits and any other death benefits the participant may have been eligible for will be provided to the Participant's surviving spouse/dependents and designated beneficiary, according to Plan rules, as if the participant was not in suspended status.

The Board of Trustees will regularly evaluate the cost of all plan benefits, rates and subsides each year. Benefits provided by the Health Fund are not vested. Therefore, at any time, the Board of Trustees may modify, end or add benefits, in its sole and absolute discretion.

This is a Summary of Material Modifications regarding the above-named plan ("Plan"). This Summary of Material Modifications supplements the Summary Plan Description ("SPD") previously provided to you. Changes communicated in this (SMM) replace previous communications that outlined same or similar benefits. You should retain this document with your copy of the SPD.

Please contact your local Fund Office if you have any questions regarding this Summary of Material Modifications.

Sincerely,

**Board of Trustees**