NORTHEAST CARPENTERS FUNDS

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SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Northeast Carpenters Health Fund has adopted the following changes to the Fund's Summary Plan Description for Participants in the Adirondack, Buffalo, Jamestown/Olean, Niagara, Rochester, South Central, and Upstate areas ("Plan") effective on the dates noted below. This document summarizes these changes so you should keep it with your Summary Plan Description ("SPD").

1. Effective January 1, 2018, the life insurance benefit under the Fund is self-insured. To reflect this change, your SPD is revised as follows:

- **All references to an insured life insurance benefit or the benefit booklet or insurance policy from Dearborn National Life Insurance Company, the Fund's former provider of insured life insurance benefits, are deleted throughout the SPD.**

- **The fifth paragraph and the first sentence of the sixth paragraph under the *Overview of the Plan* section on page 10 are deleted and replaced with the following:**

  The Fund also provides self-insured life insurance benefits.

  The Trustees have the discretion to make determinations regarding all benefits offered under the Plan, including benefits available through the Fund's HRA and WRA.

- **The *Life Insurance Benefits* section on page 35 is deleted and replaced with the following:**

Life Insurance Benefits

Life insurance benefits will be provided on a self-insured basis. If you have questions about your coverage, please contact the Northeast Carpenters Health Fund at 1-877-372-3236

The amount of coverage for active Participants is $30,000. In order to be eligible for coverage, you must have initially accumulated a $4,000 balance in your HRA. You remain eligible for this benefit as long as you are eligible for medical coverage, regardless of whether you have enrolled in such coverage. Coverage ends on the earlier of the date you cease to be eligible for medical coverage, regardless of whether you have enrolled in such coverage, or the date on which you retire and begin receiving benefits under the Northeast Carpenters Pension Fund, whichever is earlier.

Beneficiary. If you die while eligible for this benefit, the benefit is payable to your beneficiary. Your beneficiary is the person named by you on the applicable forms provided by the Fund. A designation of beneficiary will not be effective for any purpose unless and until it has been filed with the Fund. The beneficiary on file as shown by the records of the Plan at the time of your death is conclusive as to the identity of the beneficiary and payment made in accordance therewith will constitute a complete discharge of all obligations under the Plan. If no beneficiary has been designated, or if your designated beneficiary is not alive when you die, any life insurance benefits payable on your behalf will be paid to your surviving spouse, or if none, to your estate. A beneficiary may also be designated in an entered court order if the order contains a clear designation of rights to the beneficiary. A beneficiary designation in a court order meeting this requirement will govern over any prior or subsequent conflicting designation filed with the Fund.

A beneficiary may waive his or her rights as a beneficiary under the Plan in an entered court order, provided that such order contains a clear waiver of rights. A waiver in a court order meeting this requirement will govern over a prior conflicting designation that has been filed with the Fund. If such waiver is on file with the Fund and no new designation has been made, the Fund will pay your life insurance benefits in accordance with the same procedures that apply to Participants who die without designating a beneficiary, as described in the preceding paragraph.

- **The following is added to the *How to File Claims* section on page 41, to reflect the address for submission of life insurance benefit claims:**

How to File Claims

All claims for self-insured benefits must be submitted to the following addresses:

. . .

Life Insurance Benefit Claims

Northeast Carpenters Health Fund
270 Motor Parkway
Hauppauge, NY 11788
Phone: (877) 372-3236 Fax: (631) 952-9813

- **The following new subsection is added after the Claims Denial Notification subsection on page 45, to reflect the Fund's procedures for life insurance benefit claims:**

Life Insurance Claims

If a life insurance benefit claim is denied, the claimant will be notified of the claim denial within 90 days after the claim is received by the Fund Office. This period may be extended by an additional 90 days if an extension is necessary. If an extension is necessary, the claimant will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which a determination is expected to be made.

If the claim is denied, in whole or in part, the claimant will receive a written notice of the denial, which will include the following information:

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary to support the claim, and an explanation of why the material or information is necessary;
- a description of the appeal procedures and applicable time limits; and
- a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

- **The following new subsection is added under the *Appealing a Denied Claim* subsection on page 45, to reflect the Fund's procedures for appealing denied life insurance benefit claims:**

For Life Insurance Claims:

If a claimant's life insurance benefit claim is denied, in whole or in part, or if a claimant disagrees with the decision made on a claim, the claimant (or the claimant's authorized representative) may file an appeal with the Fund's Board of Trustees. The request for review must be made in writing to the Board of Trustees at Northeast Carpenters Health Fund, 270 Motor Parkway, Hauppauge, NY 11788 within 60 days after the date on which the claimant receives notice of the claim denial.

The claimant should include in the written appeal all the facts regarding the claim as well as the reason(s) the claimant feels the denial was incorrect. The claimant may submit written comments, documents and other information relating to the claim. If the claimant requests, he or she will receive reasonable access to and free copies of documents relevant to the claim.

In making a decision on review, the Board of Trustees will review and consider all comments, documents, records, and other information submitted by the claimant or the claimant's duly authorized representative, without regard to whether such information was submitted or considered during the initial claim determination. In reviewing the claim, the Board of Trustees will not automatically presume that the initial decision was correct, but will independently review the appeal. The Board of Trustees will make its decision at the next regular meeting following receipt of the appeal, unless there are special circumstances, in which case the Board of Trustees will decide the case at its second regular meeting following receipt of the appeal. If the claimant submits the appeal less than 30 days before the next scheduled Board of Trustees meeting, the Board of Trustees will decide the case at the second scheduled meeting, or, if there are special circumstances, the third meeting after it receives the appeal. If the Board of Trustees requires a postponement of the decision to the next meeting, the claimant will receive a notice describing the reason for the delay and an expected date of the decision. The Trustees will send the claimant a written notice of their decision (whether approved or denied) within 5 days of the date on which the decision is made.

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation, and application of the Plan. The decision of the Board of Trustees is final and binding. The claimant is not required to appeal a decision regarding the claim. However, the claimant must exhaust the claimant's administrative remedies before he or she has the right to seek external review or file suit in federal court. The claimant has a right to file suit in federal or state court under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") on the claim for benefits. Failure to exhaust these administrative remedies will result in the loss of the claimant's right to file suit.

- **The *Type of Administration and Funding of Benefits, Agent for Service of Legal Process,* and *Life Insurance* subsections of the *Plan Facts* section on page 62 are deleted and replaced with the following:**

Type of Administration and Funding of Benefits	The Plan is a group health plan. All benefits provided under this Plan are self-insured.
Agent for Service of Legal Process	Peter Tonia, Fund Director Northeast Carpenters Health Fund 91 Fieldcrest Avenue Edison, New Jersey 08818 (732) 417-3900 In addition, service of process can be made on the Trustees individually.
Life Insurance	Peter Tonia, Fund Director Northeast Carpenters Health Fund 91 Fieldcrest Avenue Edison, New Jersey 08818 (732) 417-3900

2. Effective for claims with a date of service on or after October 1, 2017, the claims administrator for behavioral health and substance abuse claims is Mental Health Consultants, Inc. ("MHC"). For more information, please refer to the separate benefit booklet describing your medical benefits or call MHC at (800) 255-3081 or go to www.mhconsultants.com/northeastcarpentersfunds. To reflect this change, your SPD is revised as follows:

- **The first sentence of the third paragraph under the *Overview of the Plan* section on page 10 is deleted and replaced with the following:**

The Fund provides self-insured medical, hospital, dental and vision benefits to you and your Dependents, through arrangements with Excellus and Mental Health Consultants, Inc. (for behavioral health and substance abuse benefits only).

- **The instructions for filing Medical, Dental and Vision claims, under *How to File Claims* on page 41, are deleted and replaced with the following:**

All claims for self-insured benefits must be submitted to the following addresses:

Medical (Non-Behavioral Health and Substance Abuse), Dental and Vision Claims
Excellus BlueCross/Blue Shield
PO Box 21146
Eagan, MN 55121
(877) 253-4797

Behavioral Health and Substance Abuse Claims
Mental Health Consultants, Inc.
1501 Lower State Road
Building D, Suite 200
North Wales, PA 19454
(800) 255-3081
www.mhconsultants.com/northeastcarpentersfunds

- **All references to "Excellus BlueCross BlueShield" in the *Appealing a Denied Claim* section on page 45 are deleted and replaced with "Excellus BlueCross BlueShield or MHC" and the second paragraph of that section is deleted and replaced with the following:**

  For Medical/Hospital Claims:

  If your medical/hospital claim is denied in whole or in part, or if you disagree with the decision made on a claim, you can file a first level appeal with Excellus BlueCross BlueShield, or Mental Health Consultants, Inc. ("MHC") in the case of a behavioral health or substance abuse claim. Your request for review must be made in writing to the following addresses, within 180 days after you receive notice of denial:

  Medical/Hospital Claims (Non-Behavioral Health and Substance Abuse)
  Excellus BlueCross/Blue Shield
  Customer Advocate Unit
  PO Box 4717
  Syracuse, NY 13221

  Behavioral Health and Substance Abuse Claims
  Mental Health Consultants, Inc.
  1501 Lower State Road
  Building D, Suite 200
  North Wales, PA 19454

  Appeals involving Urgent Care Claims may be made orally by calling Excellus BlueCross BlueShield at 1-877-253-4797 or, for behavioral health or substance abuse Urgent Care Claims, by calling MHC at 1-800-255-3081. If your first level appeal is denied by Excellus BlueCross BlueShield or MHC, you may file a second-level appeal with the Fund's Board of Trustees within 180 days after the date on which your first appeal is denied. This second-level of appeal is voluntary—you are not required to file an appeal with the Board of Trustees in order to be eligible to file a lawsuit under ERISA or to seek external review by an Independent Review Organization, as described below.

- **The last sentence under the *Plan Amendment or Termination* section on page 59 is deleted and replaced with the following:**

  At any time, the Fund can change insurance companies or modify its contracts with Excellus and/or MHC.

- **The contact information for Medical, Dental and Vision benefits under the *Plan Facts* section on page 62 is deleted and replaced with the following:**

Medical, Dental and Vision	Excellus BlueCross Blue Shield Website – www.excellusbcbs.com Medical and Vision Customer Service 1-877-253-4797 Dental Customer Service 1-800-724-1675_____
Behavioral Health and Substance Abuse	Mental Health Consultants, Inc. 1501 Lower State Road Building D, Suite 200 North Wales, PA 19454 (800) 255-3081 www.mhconsultants.com/northeastcarpentersfunds

3. Effective July 1, 2018, the first and second paragraphs under the *Continuing Your Participation* subsection on page 12 are deleted and all references in the SPD to the $2,000 minimum balance requirement are deleted, to reflect that once Participants meet the initial eligibility requirements to receive reimbursements from their HRA account, they are no longer required to maintain a minimum balance of $2,000 in their HRA account in order to continue to be eligible to receive reimbursement for Eligible Medical Expenses.

4. Effective January 1, 2018, the sixth paragraph under the *Continuing Your Participation* subsection on page 12 is deleted and replaced with the following, to reflect that Participants who take leave under the New York State Paid Leave Act will continue to be eligible for coverage as if they were actively at work:

Your health coverage will not end solely because your Employer is not making contributions on your behalf if you are absent from Covered Employment due to your pregnancy, active military service, Family and Medical Leave (see page 18), or because you are receiving New York State Disability Income benefits or workers compensation benefits. However, if your HRA balance is not sufficient to cover your premiums during such periods of absence, you will be required to self-pay the difference in order to maintain your coverage. In addition, your health coverage will not end solely because your Employer is not making contributions on your behalf if you are absent from Covered Employment due to leave under the New York State Paid Leave Act.

5. Effective January 1, 2018, the *Disabled Participants* subsection of the *About Your Participation* section on page 14 is deleted and replaced with the following, and the following new *Participants Attending Apprenticeship Classes* subsection is added, to reflect that Participants' HRAs will be credited with contributions during periods they are receiving New York State Disability Income benefits or workers compensation benefits or attending apprenticeship classes:

Disabled Participants. If a Participant is receiving New York State Disability Income or workers compensation benefits, participation in the Plan will continue for as long as the Participant is receiving such benefits, provided the Participant's period of total disability began while he or she is an Active Participant and the Participant pays the required premiums for medical, dental and prescription drug coverage, either from his HRA or if the balance of his HRA is insufficient, through direct self-pay. The Fund will credit a Participant's HRA with up to 30 hours of contributions per week (up to 52 weeks per year) for periods in which the Participant is receiving New York State Disability Income or workers compensation

benefits, if the Participant submits evidence satisfactory to the Fund confirming his receipt of such benefits. You can also continue to submit claims for the reimbursement of Eligible Medical Expenses.

Participants Attending Apprenticeship Training. The Fund will credit an Apprentice Participant's HRA with up to 40 hours of contributions per week for each week the Participant spends in the Apprenticeship training program of the Northeast Carpenters Apprenticeship Fund.

6. Effective November 1, 2017, the first paragraph under the *Forfeiture of HRAs and WRAs* subsection on page 16 is deleted and replaced with the following, to reflect that HRA and WRA balances that have been forfeited due to no activity will be reinstated if the Participant re-satisfies the initial eligibility requirements for coverage within three (3) years of the forfeiture:

Any balance in your HRA and/or WRA will be forfeited following 36 consecutive months of no activity with respect to your HRA or WRA (no activity means that no Employer contributions have been made to your account and no amounts have been deducted from your account to pay premiums or claims for Eligible Medical Expenses). Forfeiture will occur on the last day of the 36th month and will be used for Fund administrative expenses. It is your responsibility to monitor the activity in your HRA and WRA. The Fund Office is not required to provide notice prior to any forfeiture. The forfeiture rules described in this paragraph do not apply to anyone who has retired from the Northeast Carpenters Pension Fund (or prior plans that merged into the Pension Fund) and remains eligible for an HRA. If your HRA and/or WRA balance is forfeited pursuant to this paragraph and you return to employment for which contributions are made to the Fund on your behalf, and as of the third anniversary of the date your HRA and/or WRA balance was forfeited, you have re-satisfied the initial eligibility requirements for coverage, you may apply to the Fund Office for reinstatement of the amount forfeited from your HRA and/or WRA. No forfeited balances are eligible for reinstatement if more than three (3) years has passed since the date of the forfeiture.

7. Effective May 22, 2018, the *Dependent Participation, Disabled Child* subsection on page 17 is deleted and replaced with the following, to reflect that a Participant's dependent child will be eligible for coverage under the Plan as the Participant's disabled child only if the Social Security Administration has determined that the child is totally disabled:

3. **Disabled children.** If your unmarried child turns age 26 while covered under the Plan and is, at that time, totally disabled as determined by the Social Security Administration ("SSA"), the child will continue to qualify as an eligible dependent for as long as the child remains totally disabled as determined by the SSA and you remain covered under the Plan. You must submit written proof of the SSA's determination of your child's total disability to the Fund Office within 31 days of the date the child's eligibility would have otherwise ceased. Unless the SSA has determined that a disability is a "permanent disability," the Participant must submit proof each year prior to the Open Enrollment Period demonstrating the SSA's determination that the Dependent continues to be totally disabled. If such proof is not sufficient or is not timely submitted, coverage will terminate.

8. Effective January 1, 2018, the second paragraph of the *Health Reimbursement Account* section on page 24 is deleted and replaced with the following, to reflect that an experimental treatment or service is reimbursable from the Health Reimbursement Account provided that it qualifies as a tax deductible medical expense under IRS rules:

In addition, once your initial HRA balance reaches $4,000, your HRA can be used to reimburse you for Eligible Medical Expenses. In addition to an expense being included in Appendix A (as may be amended from time to time) Eligible Medical Expenses cannot otherwise be reimbursed from insurance or from some other source, such as an employer sponsored flexible spending account. The Fund will not reimburse any expenses that are not Medically Necessary, including but not limited to services that are cosmetic, unless the expense is for an Experimental treatment or service. Your HRA can be used to reimburse you for any Experimental treatments or services that are tax deductible medical expenses under Section 213 of the Internal Revenue Code.

9. Effective May 22, 2018, the following is added to the end of the fourth paragraph of the *Health Reimbursement Account* section on page 24, to reflect that the Fund may suspend your eligibility to receive reimbursement from your HRA if you fail to cooperate with the Fund's attempt to recover an overpayment of benefits to you or your dependent:

If you fail to cooperate with any attempt by the Fund to recover any overpayment or advancement of benefits to you or your dependent, as described in the Overpayments section of this SPD, the Fund may suspend your eligibility to receive reimbursement from your HRA.

10. Effective January 1, 2018, the following is added to the end of the *Health Reimbursement Account* section on page 24, to reflect the new health debit card for Participants who are eligible for an HRA:

Health Debit Card. The Fund will provide eligible Participants with a health debit card that may be used to reimburse you for Eligible Medical Expenses. You may use the debit card at your doctor's office, retail pharmacy or mail order pharmacy to pay for Eligible Medical Expenses. Once you have made a purchase on your debit card, you should retain the documentation substantiating that your purchase is for an Eligible Medical Expense, including receipts and explanations of benefits. The Fund retains the discretion to determine whether any expense paid using your debit card is an Eligible Medical Expense and you may be required to submit to the Fund Office substantiation satisfactory to the Fund, as described above. If you lose your debit card or otherwise need a replacement card, you can request a set of replacement cards and a $5 fee for the cost of the replacement cards will be deducted from your HRA balance.

For any questions regarding your health debit card, you should contact the Fund Office.

11. Effective January 1, 2018, the following is added to the end of the *Time Loss Benefit* subsection of the *Wage Replacement Account* section on page 25, to reflect that apprentices are eligible to receive time loss benefits from their wage replacement account for any week in which they attend apprenticeship classes:

In addition, apprentices are eligible to receive the time-loss benefit for any week in which they attend apprenticeship classes, regardless of whether they are registered on an "out of work" list, provided the Fund receives confirmation of their attendance from the apprentice school.

12. Effective July 1, 2017, the last paragraph of the *Retiree Coverage* subsection of the *Special Coverage Information* section on page 28 is deleted and replaced with the following, to reflect that Medicare-eligible retirees may be eligible to continue in the Fund's dental benefit program:

Medicare-Eligible Retirees and spouses. You can use any balance remaining in your HRA to reimburse any Eligible Medical Expenses listed in Appendix A. However, you are not eligible to continue in the Fund's medical, vision or life insurance benefit programs. If you are interested, you can enroll in one of the Medicare Advantage Plans offered through the Funds. Please contact the Fund Office for more information.

13. Effective July 1, 2018, the co-payment for a generic drug filled at a retail pharmacy (up to 34-day supply) is reduced to $5.00 and the co-payment for a generic drug filled by mail order (up to 90-day supply) is reduced to $10.00. To reflect this change, effective July 1, 2018, the Prescription Drug Benefits section on pages 32-33 of your SPD is revised to read as follows:

At Participating Retail Pharmacies

. . .

Your Co-payment is:

- $5.00 if the prescription or refill is filled with generic drugs,

. . .

Using the Mail Order Pharmacy

. . .

For up to a 90-day supply of a covered medication, Participants pay a Co-payment of:

- $10.00 if the prescription or refill is filled with generic drugs;

14. Effective July 1, 2017, the following section for *Lodging and Transportation Expenses* is added to Appendix A, *Eligible Medical Expenses*:

Healthcare Expense Type	Substantiation Requirements
Lodging and Transportation Expenses – Lodging expenses for a Participant or Dependent are reimbursable if (1) the lodging is primarily for, and essential to, medical care; (2) the medical care is provided by a physician at a licensed hospital or a medical care facility that is related to, or the equivalent of, a licensed hospital; and (3) there is no significant element of personal pleasure, recreation or vacation in the travel away from home. Lodging expenses are also reimbursable for one companion of the patient if the presence of the companion is necessary for the patient to receive medical care. In no event will any reimbursement for lodging exceed $50 per night per person. Transportation costs, including parking fees, are also reimbursable if: 1) they are incurred primarily for, and essential to, the receipt of medical care by the Participant or Dependent; and 2) are incurred in connection with lodging expenses reimbursed from the HRA. Transportation costs of a family member traveling with the Participant or Dependent are also reimbursable if the family member's presence is necessary for the patient to receive medical care. In no event will transportation costs be reimbursed unless they are incurred in connection with reimbursable lodging expenses.	• Records from the hospital or equivalent facility showing the dates of treatment, diagnosis, and services rendered. • A statement from a licensed physician explaining why treatment was required at the particular hospital or facility. • Receipts for the lodging expenses. • For transportation costs, receipts for the transportation expenses and statement as to why the transportation costs were necessary to receive medical treatment.

15. Effective January 1, 2018, Appendix A, *Eligible Medical Expenses*, is deleted and replaced with the following:

Appendix A

Eligible Medical Expenses

Please remember that just because an expense is included on this list, does not mean that it is automatically reimbursable from the Health Reimbursement Account. All the applicable requirements described in the SPD must be met in order for your claim to be eligible for reimbursement. In addition, the Fund reserves the right to request additional information that is not included in this Appendix to determine whether a particular expense is reimbursable.

Healthcare Expense Type	Substantiation Requirements
Co-Payments, Co-insurance, Deductibles and expenses that exceed the Usual or Customary Charges paid to out-of-network providers for expenses. This includes, but is not limited to, doctors, hospitals, urgent care facilities, laboratory services, radiology services, ambulance transport, mental health services, substance abuse treatment, orthotics and prosthetics.	• Explanation of Benefits (EOB) or Health Statement • If payment is being made to the covered person, proof of payment (original receipts or a clearly legible photocopy). • If payment is being made directly to the provider, you must provide an assignment claim form and a W-9 Form completed by the provider • If an EOB or Health Statement is not available or if payment is being made directly to the provider, you must submit an itemized bill which must include: 1. Date of service 2. Patient name 3. Description of services rendered (procedure code and diagnosis code if available) 4. Cost of services rendered 5. Name and address of provider.
Medical Premiums • Post-tax medical, dental or vision premiums that are paid to a qualified group health plan. • Government sponsored health plans (such as Medicare) • COBRA premiums that are paid to a qualified group health plan • Premiums that are self-paid to the Fund with after-tax dollars during a period in which your Employer is delinquent • Does **not** include the cost of purchasing individual market insurance (such as through a State Health Plan marketplace)	• Acceptable Proof: 1. Proof that premiums are paid with "after tax dollars," such as a letter from Human Resources or Payroll department. 2. Paycheck stub showing the amount of premiums paid. Pay stub must also include; date the check was issued, name of person the check is issued to and the amount of premium deducted. 3. Proof that the plan is a qualified group health plan. 4. Copies of Medicare statements or invoices are acceptable. 5. For COBRA premiums, proof must include a letter from the Plan Administrator certifying the COBRA rate and proof that you have paid the full premium.
Dental and Orthodontic Services • Premiums for Fund's dental plan • Premiums you pay to purchase your own dental coverage with after tax-dollars • Dental services for the prevention and alleviation of dental disease, including preventive services such as teeth cleaning, sealants, and fluoride treatments, and services such as X-rays, braces (adult or child), extractions or dentures. Cosmetic dental services and teeth whitening are not reimbursable.	• For premiums for the Fund's dental plan, you do not need to present any additional documentation. If you elect this coverage, the Fund will automatically deduct the monthly premiums from your HRA. • For premiums for insurance you purchase on your own, you must provide an invoice from the insurance; proof of payment and proof that payment was made with after-tax dollars. • For dental or orthodontic Services - Explanation of Benefits (EOB) if you have dental coverage or a bill from your provider if you do not have dental coverage; - If reimbursement is being made directly to you, proof of payment is required; - If payment is being made directly to the

	provider, you must submit an assignment claim form and a W-9 form completed by the provider; - Orthodontics also require a signed and dated Orthodontic contract with provider information, patient name, payment plan selected and the amount, of any an insurance company is estimated to pay.
Drugs/Medicines – **Prescriptions** Expenses for fertility drugs and over-the-counter-drugs, including vitamins and supplements, are reimbursable only if the Participant or Dependent, as applicable, has a prescription from a doctor or other authorized medical professional. Marijuana is not reimbursable. In order for vitamins and nutritional supplements to be reimbursed, they must be recommended by a licensed medical practitioner as treatment for a specific medical condition that was diagnosed by a physician.	• Documentation from the Pharmacy that must include all of the following: 1. Name and Address of Pharmacy 2. Name of patient 3. Name of Drug 4. Cost of Drug and any amounts covered by insurance 5. Prescribing doctor • If payment is being made directly to the covered person, proof of payment (original receipts or a clearly legible photocopy). • If payment is made directly to the provider, you must provide an assignment form and a W-9 Form completed by the provider. • For vitamins and nutritional supplements, you must also provide a letter from a licensed medical provider explaining the medical condition and how the vitamin/supplement is expected to treat that condition.*
Vision Care • Prescription eyewear includes Frames/Lenses, Contact lenses and Prescription Safety Glasses • Eye examinations by a licensed ophthalmologist, optometrist or optician • Laser surgery	• Explanation of Benefits (EOB) of Health Statement is preferable • If payment is being made to the covered person, proof of payment (original receipts required or a clearly legible photocopy). • If payment is being made directly to the provider, you must provide an assignment form and a W-9 Form completed by the provider • If an EOB or Health Statement is not available or if payment is being made directly to the provider, you must submit an itemized bill which must include: 1. Date of service 2. Patient name and date of birth 3. Description of services rendered (procedure code and diagnosis code if available). 4. Cost of services rendered 5. Name and address of provider.
Hearing • Purchase price and maintenance cost for hearing aids • Batteries needed to operate the hearing aid • Hearing exams **You can seek reimbursement from the HRA for hearing services, provided all the other requirements of this SPD are satisfied and you submit a copy of your prescription and a letter of medical necessary.**	• Explanation of Benefits (EOB) or Health Statement • If payment is being made to the covered person, proof of payment (original receipts or clearly legible photocopy). • If payment is being made directly to the provider, you must provide an assignment form and a W-9 Form completed by the provider • If an EOB is not available or if payment is being made directly to the provider, you must submit an itemized bill which must include: 1. Date of service 2. Patient name 3. Description of services rendered (procedure code) and diagnosis code if available 4. Cost of services rendered 5. Name and address of provider.

Durable Medical Equipment • Must have a prescription for the equipment	• Copy of the prescription or proof that the equipment was prescribed • Letter of Medical Necessity • Proof of payment, if not being paid directly to provider • If payment is being made directly to the provider, submit an assignment claim form and a completed W-9 Form • Documentation that includes the following: 1. Name and Address of Company proving the equipment 2. Name of patient 3. Type of Equipment 4. Cost of Equipment and any amounts covered by insurance 5. Prescribing doctor
Lodging and Transportation Expenses – Lodging expenses for a Participant or Dependent are reimbursable if (1) the lodging is primarily for, and essential to, medical care; (2) the medical care is provided by a physician at a licensed hospital or a medical care facility that is related to, or the equivalent of, a licensed hospital; and (3) there is no significant element of personal pleasure, recreation or vacation in the travel away from home. Lodging expenses are also reimbursable for one companion of the patient if the presence of the companion is necessary for the patient to receive medical care. In no event will any reimbursement for lodging exceed $50 per night per person. Transportation costs, including parking fees, are also reimbursable if: 1) they are incurred primarily for, and essential to, the receipt of medical care by the Participant or Dependent; and 2) are incurred in connection with lodging expenses reimbursed from the HRA. Transportation costs of a family member traveling with the Participant or Dependent are also reimbursable if the family member's presence is necessary for the patient to receive medical care. In no event will transportation costs be reimbursed unless they are incurred in connection with reimbursable lodging expenses.	• Records from the hospital or equivalent facility showing the dates of treatment, diagnosis, and services rendered. • A statement from a licensed physician explaining why treatment was required at the particular hospital or facility. • Receipts for the lodging expenses. For transportation costs, receipts for the transportation expenses and statement as to why the transportation costs were necessary to receive medical treatment.
Massage Therapy To be eligible for reimbursement, you must demonstrate to the satisfaction of the Fund, a clear and direct connection between the massage therapy and the treatment, cure, or mitigation of a specific medical condition.	Proof of payment Invoice from the provider explaining the services rendered and Explanation of Benefits (EOB); and A letter from a licensed medical provider explaining your medical condition and how the recommended massage therapy is expected to treat that condition*
Dietary Food and Infant Formula To be eligible for reimbursement, these items must be: (1) prescribed by a physician; (2) in addition to the individual's normal diet; and (3) not part of the individual's normal nutritional needs. Expenses will not be reimbursed for any special food, beverage or formula that is taken as a substitute for that which is normally consumed by a person and satisfies	A prescription for the specific food/formula A letter from a licensed medical provider explaining why this food/formula is necessary and how it is supplemental to, and not a substitute for, the individual's normal nutritional needs*; and Proof of payment.

his or her normal nutritional requirements.	
Expenses for procedures to treat infertility. This does **not** include procedures to reverse elective sterilizations and other procedures performed to limit or avoid fertility, such as vasectomies and tubal ligations.	• Explanation of Benefits (EOB) or Health Statement • If payment is being made to the covered person, proof of payment (original receipts or a clearly legible photocopy). • If payment is being made directly to the provider, you must provide an assignment claim form and a W-9 Form completed by the provider • If an EOB or Health Statement is not available or if payment is being made directly to the provider, you must submit an itemized bill which must include: 6. Date of service 7. Patient name 8. Description of services rendered (procedure code and diagnosis code if available) 9. Cost of services rendered Name and address of provider.
Acupuncture performed by a licensed professional.	Proof of payment and Explanation of Benefits (EOB) from insurance; and Invoice from the provider explaining the services rendered.
Stop-Smoking Programs. Expenses for programs to stop smoking are reimbursable. However, expenses for drugs designed to help stop smoking that do not require a prescription, such as nicotine gum or patches, are not reimbursable.	Proof of payment; and Invoice from the provider explaining the services rendered.
Weight-Loss Programs. Expenses for a program to lose weight are reimbursable, provided it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. Expenses will not be reimbursed for membership dues in a gym, health club, or spa, except for separate fees charged there for weight loss activities. Expenses for the cost of diet food or beverages in excess of the cost of a normal diet are reimbursable, but only if the food doesn't satisfy normal nutritional needs, the food alleviates or treats an illness, and the need for the food is substantiated by a physician.	Proof of payment; Invoice from the provider explaining the services rendered; and A letter of medical necessity from a licensed medical provider.

* The letter required to substantiate a claim for these expenses must specify the period of time for which the course of treatment is required and an explanation as to why this period of time is appropriate for your condition. The Fund will reimburse claims only for the period of time specified in the letter, but in no event more than 12 months. If the particular course of treatment is prescribed for more than a 12-month period, you must submit a new letter at least every 12 months in or for your claim to be eligible for reimbursement, If your treatment is extended beyond the period of time specified in your letter, a new letter must be provided to the Fund,

Remember- just because your medical provider recommends a course of treatment does not mean that it will be eligible for reimbursement from your HRA. It must meet all the requirements described in this document.

The following list provides examples of items that are NOT eligible for reimbursement for your HRA. This list is provided as an example and is not exhaustive.

- Air conditioners and vacuums
- Athletic Club Memberships
- Foods and Beverages, except as otherwise provided above.
- Hot Tubs, Whirlpools, Swimming Pools, Exercise equipment, etc.
- Learning Materials
- Nutrition and Dietary Planning (except Dietary Food as noted above)
- Tanning Bed
- Cancellation Fees
- Missed Appointment Fees
- Late Payments
- Legal Fees
- Shipping Fees
- Extended Warranties for Durable Medical Equipment
- New York State medical surcharges
- Marijuana
- Vitamins (except as noted above)
- Over-the-counter medical supplies (except as noted above), such as bandages and medical tape.
- Capital Expenses, including expenses for home improvements and lead-based paint removal.
- Cars
- Christian Science Practitioner fees.
- Guide Dogs or Other Service Animals
- Long-Term Care insurance premiums and services
- Payments to Medical Expense Debt Collectors and other debt collection agencies.

If you have any questions, please contact the Fund Office.

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