NCF
NORTHEAST CARPENTERS FUNDS

(631) 952-9700 • 1-877-372-3236 • www.nrccf.org
270 Motor Pkwy., Hauppauge, NY 11788-5150

October 2018

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 active Participants and their eligible Dependents in the Long Island, Westchester, Hudson Valley, Albany and Rockland 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 July 1, 2018, when an active Participant applies for retirement benefits and qualifies for retiree health coverage, the Participant will qualify to extend their active health coverage out beyond their retirement date. If, prior to their retirement date, the Participant earns coverage, through contributions made to the Health Fund, for the previous two benefit coverage periods, they will be eligible for coverage during the benefit coverage period in which they retire, as well as during the two future benefit coverage periods in retirement.

Example of retiree health coverage – two future benefit coverage periods in retirement:

Carpenter Joe retires on February 1, 2019. Joe had benefit coverage in the two previous benefit coverage periods; October 2017 to March 2018 and April 2018 to September 2018. He therefore qualifies for health coverage through March 2020 (the end of the benefit coverage period in which he retired – March 2019; and then two additional benefit coverage periods).

If an active Participant qualifies for retiree health coverage at the time of their retirement date, and had earned coverage, through contributions made to the Health Fund, for the previous benefit coverage period, but not the previous two consecutive benefit coverage periods, prior to their retirement date, they will be eligible for health coverage to the end of the benefit coverage period in which they retire as well as one additional benefit coverage period, in retirement.

Example of retiree health coverage – one future benefit coverage period in retirement:

Carpenter Joe retires on February 1, 2019. Joe had benefit coverage in the one previous benefit coverage period; April 2018 to September 2018. He therefore qualifies for health coverage through September 2019 (the end of the benefit coverage period in which he retired – March 2019; and then one additional benefit coverage period).

2. 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 Life Insurance Benefits section on page 52 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.

Life Insurance benefits are payable to your beneficiary if you die while coverage is in effect. If you are eligible for coverage, your beneficiary will receive $30,000 upon your death.

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 63, to reflect the address for submission of life insurance benefit claims:**

How to File Claims

All claims must be submitted as follows:

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 68, 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 69, 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* and *Life Insurance* subsections of the *Plan Facts* section on page 86 are deleted and replaced with the following:**

Type of Administration and Funding of Benefits	The Fund is a self-insured multiemployer welfare plan. The only insured benefits offered under the Plan are dental.
Life Insurance	Peter Tonia, Fund Director Northeast Carpenters Health Fund 91 Fieldcrest Avenue Edison, New Jersey 08818 (732) 417-3900

3. Effective for claims with a date of service on or after October 1, 2017, the claims administrator for mental and behavioral health and substance abuse claims is Mental Health Consultants, Inc. ("MHC") and the Plan no longer provides an Employee Assistance Program through Lower Hudson Valley EAP. 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 these changes, your SPD is revised as follows:

- **The fifth paragraph of the definition for *Hospital/Facility* in the *Definitions* section on page 9 is deleted and replaced with the following:**

  For mental and behavioral health and substance abuse care purposes, the definition of "Hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that is in Mental Health Consultants, Inc.'s ("MHC") participating provider network.

- **The following paragraph is added to the definition for an *In-Network Provider/Supplier* in the *Definitions* section on page 10:**

  For mental and behavioral health and substance abuse services, an In-Network Provider/Supplier is a provider, supplier or Facility that is in MHC's participating provider network.

- **The following paragraph is added to the definition for *Out-of-Network Providers/Suppliers* in the *Definitions* section on page 11:**

  For mental and behavioral health and substance abuse services, an Out-of-Network Provider/Supplier is a provider, supplier or Facility that is not in MHC's participating provider network.

- **The second paragraph under the *Mental Health Care* subsection of the *Eligible Medical Expenses* section on page 43 is deleted.**

- **The *Employee Assistance Program* section on page 50 is deleted.**

- **The instructions for filing In-Network and Out-of-Network Medical Claims and Employee Assistance Program Claims, under *How to File Claims* on page 63, are deleted and replaced with the following:**

All claims must be submitted as follows:

In-Network and Out of Network Medical (Non-Mental and Behavioral Health and Substance Abuse) Claims
Empire BlueCross/Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10018

Medical Claims for Participants Eligible for Medicare
Northeast Carpenters Health Fund
91 Fieldcrest Avenue
Edison, NJ 08818
Attn: Medicare

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

- **The contact information for Medical/Hospital and Employee Assistance Program benefits under the *Plan Facts* section on page 86 is deleted and replaced with the following:**

Medical/Hospital	In-Network and Out of Network: Empire Blue Cross and Blue Shield P.O. Box 1407 Church Street Station New York, NY 10008 (212) 476-1000
Mental and 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

4. Effective July 1, 2018, the last paragraph under the *When Your Participation Begins* subsection on page 13 is deleted and replaced with the following, to reflect new eligibility rules for the participation of owner-operators in the Fund:

An owner-operator, who is an owner of a contributing Employer and performs both Covered Employment and non-Covered Employment, is eligible to participate in the Fund pursuant to a written participation agreement with the Board of Trustees, provided the Employer makes contributions on his behalf for a minimum of 1500 hours per year

and such participation agreement was in effect prior to July 1, 2018. For participation agreements with an effective date on or after July 1, 2018, the owner-operator also must have been previously covered under a collective bargaining agreement with the Union that required contributions to the Fund and the Employer must make contributions on his behalf for a minimum of 1800 hours per year to the Fund and all other funds to which Contributing Employers contribute pursuant to a collective bargaining agreement with the Union that requires contributions to the Fund.

5. Effective January 1, 2018, the *Covered Employment and Apprenticeship* subsection on page 15 is deleted and replaced with the following, to reflect that the maximum number of hours per week spent in apprenticeship classes that will be credited purposes of continued eligibility in the Fund is increased from 35 hours to 40 hours:

Covered Employment and Apprenticeship Training. For the purposes of continued eligibility in the Northeast Carpenters Health Fund, hours spent in the Apprenticeship training program of the Northeast Carpenters Apprenticeship Fund will be credited as covered employment at a rate of one hour for every hour spent in training, for up to 40 hours per week.

6. 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 if, and only if, the Social Security Administration has determined that the child is totally disabled:

Disabled Child. 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 child has been determined by the SSA to be permanently disabled, the Fund will require annual proof of total disability. If proof is not sufficient or is not timely submitted, coverage will terminate.

7. Effective January 1, 2018, the following new subsection is added after the *Continued Coverage During a Family and Medical Leave* subsection in the *About Your Participation* section on page 19, 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:

Continued Coverage During Leave Under the New York State Paid Leave Act

Your health coverage will not end solely because you are absent from Covered Employment due to leave under the New York State Paid Leave Act. For the purposes of

continued eligibility for coverage under the Plan, leave under the New York State Paid Leave Act will be credited as Covered Employment.

8. Effective July 1, 2018, the Plan pays 120% of the Medicare allowed charge for Out-of-Network medical benefits. For Out-Of-Network medical benefits, you are responsible to pay any amount charged by your provider that exceeds 120% of the Medicare allowed charge, in addition to any Deductible that is required under the Plan. To reflect this change, your SPD is revised as follows:

- **The *Medical* benefits subsection of the chart of *Benefits For Active Participants* on page 25 is deleted and replaced with the following:**

BENEFITS FOR ACTIVE PARTICIPANTS			
Benefit	**How It Works In General**	**Who's Eligible**	
		EMPLOYEES	**DEPENDENTS**
Medical hospitalization, major medical, Doctor treatment, chiropractic treatment	**In-Network** When you go to an In-Network provider for your care, the Plan pays 100% of the reasonable and customary charges for hospital care and, after a $20-per-visit copayment, 100% of most other eligible medical expenses (subject to Plan limits). For emergency room visits, you are required to pay a $100 per-visit co-payment (waived if admitted). Your out-of-pocket in-network expenses are capped at $3,000 individual/$6,000 family per year for medical expenses. **Out-of-Network** When you go to an Out-of-Network provider for your care, the Plan pays 120% of the Medicare allowed charge for hospital care and most other eligible medical expenses (subject to Plan limits); after a $200/family annual deductible. You are responsible to pay any amount charged by your provider that exceeds 120% of the Medicare allowed charge, in addition to any applicable deductible. Hospital Emergency treatment is provided on an in-network basis.	Yes	Yes

- **The *Out-of-Network Coverage* subsection of the *How Medical Expenses Are Paid* section on pages 29-30 is deleted and replaced with the following:**

Out-of-Network Coverage

When you go to an Out-of-Network provider for your care, the Plan pays 120% of the Medicare allowed charge for Hospital care and most other eligible medical expenses after the $200 family annual deductible, and subject to Plan limits. For Hospital emergency room visits for a medical emergency, you are required to pay a $100 per visit co-payment (waived if admitted within 24 hours).

Please Note: When you go to an Out-of-Network provider for your care, the provider may bill you for the difference between the provider's actual charge and the 120% of Medicare allowed charge covered under the Plan. This additional charge is not paid by the Plan. This provider practice is called "balance billing".

*Annual Deductible***.** Each participant must satisfy the $200 family annual Deductible. However, if you have family coverage, the family annual Deductible is considered satisfied once your family's combined eligible expenses reach $200.

The following expenses are not applied toward the Out-of-Network annual Deductible:

- In-Network Co-payments;
- Out-of-Network expenses that exceed 120% of the Medicare allowed charge;
- amounts that you pay because you failed to meet the Pre-certification or other similar requirements; and
- charges excluded or limited by the Plan.

Keep in mind that there is no coverage for any service or supply that is not considered medically necessary.

- **The chart of *Eligible Medical Expenses* beginning on page 31 is deleted and replaced with the following:**

ELIGIBLE MEDICAL EXPENSES		
Provision	**How It Works**	
	IN-NETWORK	OUT-OF-NETWORK
How you access care	Go to any In-Network Provider	Go to any licensed/certified Doctor, Hospital or Facility
Basis for reimbursement	All In-Network reimbursements are based on the negotiated charge for Medically Necessary eligible expenses and subject to Pre-certification when required	All Out-of-Network reimbursements are based on 120% of the Medicare allowed charge for Medically Necessary eligible expenses and subject to the annual Deductible and to Pre-certification when required
Annual Deductible Family	N/A	$200
Co-payments (where applicable)	$20/visit	N/A
Coinsurance (where applicable)	Plan pays 100%	N/A

ELIGIBLE MEDICAL EXPENSES		
Provision	**How It Works**	
	IN-NETWORK	OUT-OF-NETWORK
Annual out-of-pocket maximums Out-of-pocket maximums do not include: dental premiums; out-of-network deductibles; balance-billed charges; penalties for failure to pre-certify; and health care costs this plan does not cover.	$3,000/Individual and $6,000/Family for medical benefits $3,600/Individual and $7,200/Family for prescriptions	N/A
Office visits	$ 20 Co-payment per visit	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Specialist visits	$ 20 Co-payment per visit, subject to a maximum of 12 visits per year.	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible, subject to a 12-visit annual maximum.
Podiatrist visits	$ 20 Co-payment per visit, subject to a maximum of 24 visits per year	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible, subject a 24-visit per year maximum.
Chiropractic visits	$ 20 Co-payment per visit, subject to a maximum of 30 visits per year	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible, subject to a 30-visit per year maximum.
Second or third surgical opinion*	$ 20 Co-payment per visit; waived if arranged through the Empire BlueCross BlueShield Medical Management Program	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Allergy testing	$ 20 Co-payment per visit	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Allergy treatment	$ 20 Co-payment per visit	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Diagnostic procedures: • X-rays and other imaging* • MRIs/MRAs • All lab tests	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Surgery	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible

Chemotherapy	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
X-ray, radium and radionuclide therapy	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
PREVENTIVE CARE		
Preventive care includes services on annual government lists subject to some age and frequency limitations. See page 37.		
Annual physical exam	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Diagnostic screening tests with PEMG: • Cholesterol (two years) • Diabetes • Colorectal cancer • Routine PSA tests in asymptomatic males	Plan pays 100% for services covered on government lists	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible for services covered on government lists.
Well-woman care: • Office visits • Pap smears • Mammogram	• Plan pays 100% for services covered on government lists	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible for services covered on government lists.
Well-child care, immunizations, office visits and associated lab services provided within 5 days of office visit	Plan pays 100% for services covered on government lists	Plan pays 120% of the Medicare allowed after satisfaction of the Deductible for services covered on government lists.
EMERGENCY CARE		
Hospital Emergency room*	$100 Co-Payment per visit (waived if admitted to the same Hospital within 24 hours)	
Office visits	$ 20 Co-payment per visit	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Ambulance (local professional ground ambulance to the nearest Hospital or air ambulance* to nearest acute care Hospital for emergency or inpatient admissions)	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
MATERNITY CARE		
Office visits for prenatal and postnatal care	$20 Co-payment for the first prenatal visit; then Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible

Diagnostic procedures: • Sonograms • Lab tests • Other diagnostic procedures	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Routine newborn in-hospital nursery care	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Obstetrical care* (in Hospital or birthing center)	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
IN-PATIENT HOSPITAL CARE*		
Anesthesia and oxygen	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Blood work	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Cardiac rehabilitation	$20 Co-payment per outpatient visit	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Chemotherapy and radiation therapy	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Diagnostic x-rays and lab tests	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Drugs and dressings	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
General, special and critical nursing care	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Intensive care	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Kidney dialysis	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Pre-surgical testing	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Semi-private room and board	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
In-hospital services of licensed Doctors and surgeons	Plan pays 100%, subject to a maximum of 2 visits per day.	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible

Surgery (inpatient or outpatient; benefits are limited for multiple surgeries through the same incision)	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
Durable medical equipment* (such as wheelchairs and hospital beds)	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible (benefits for durable medical equipment for the injection of insulin will be covered once in a 5-year period)
Orthotics*	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Prosthetics* (such as artificial limbs)	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
Medical supplies (such as catheters and syringes)	Plan pays 100%	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible
SKILLED NURSING AND HOSPICE CARE FACILITIES		
Skilled Nursing Care Facility*	Plan pays 100%, subject to a maximum of 60 days per year	Plan pays 120% of the Medicare allowed charges subject to a maximum of 60 days per year
Hospice care facility*	Plan pays 100%, subject to a lifetime maximum of 210 days	Plan pays 120% of the Medicare allowed charges subject to a lifetime maximum of 210 days (bereavement counseling is limited to 5 visits)
HOME HEALTH CARE		
Home health care visits*	Plan pays 100%, subject to a maximum of 200 visits per year	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible, subject to a maximum of 200 visits per year
Home infusion therapy	Plan pays 100%	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY		
Physical therapy and rehabilitation* • Inpatient services • Outpatient services	• Plan pays 100% for in-patient services • $20 Co-payment per visit for out-patient services • Maximum of 30 visits per year	Plan pays 120% of the Medicare allowed charges, subject to a 30-day per year maximum
Occupational, speech or vision therapy*	$ 20 Co-payment per visit, subject to a maximum of 30 visits per year	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible, subject to a maximum of 30 visits per year
Autism Therapy	$20 Co-payment per visit	Plan pays 120% of the Medicare allowed charges after the satisfaction of the Deductible

MENTAL HEALTH CARE		
The Fund covers mental health treatment on both an inpatient and outpatient basis to the same extent it covers inpatient and outpatient medical care. This means that the same financial terms and treatment limitations that apply to medical care will also apply to mental health and substance abuse care.		
ORGAN AND TISSUE TRANSPLANTS*		
Organ and tissue Procurement	Plan pays 100% of eligible transplant-related expenses as long as they are coordinated and approved by the Empire BlueCross BlueShield Medical Management Program and provided by Empire Centers of Excellence**	Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible, up to $10,000 per Transplant
Transportation, lodging and meals		Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible up to $10,000 per Transplant Benefit Period and to $250 per day
Private duty nursing		Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible up to $5,000 per Transplant Benefit Period
Other charges		Plan pays 120% of the Medicare allowed charges after satisfaction of the Deductible

* Pre-certification required.
** Empire Centers of Excellence are a national and local organ transplant network that gives members access to hospitals and medical professionals with demonstrated expertise and success in performing organ transplants.

- **The *Out-of-Network* subsection of the *Preventive Care* section on page 37 is deleted and replaced with the following:**

  Out-of-Network

  The Plan covers the same preventive services on out-of-network basis as it does on an in-network basis described above, including routine physicals for all covered persons. The Plan pays 120% of the Medicare allowed charges after you have satisfied the Deductible.

- **The second paragraph of the Emergency Care section on page 38 is deleted and replaced with the following:**

  For other emergency care services, such as a Doctor's Office visit, if you go to an In-Network provider, you will pay a $20 co-payment; if you go to an Out-of-Network provider, you will pay expenses that exceed 120% of the Medicare allowed charge, plus any applicable deductible.

9. Effective November 1, 2017, the following new paragraph is added to the beginning of the *Forfeiture of Supplemental Health Reimbursement Account* subsection on page 54 and the *Balance in Your Supplemental Health Reimbursement Account after Your Death* subsection on page 55 is deleted and replaced with the following, to reflect that Supplemental Health Reimbursement Account 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 Supplemental Health Reimbursement Account will be forfeited following 36 consecutive months of no activity (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 Supplemental Health Reimbursement Account. 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 a Supplemental Health Reimbursement Account. If your Supplemental Health Reimbursement Account balance is forfeited pursuant to this paragraph and you return to Covered Employment, and as of the third anniversary of the date your 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 Supplemental Health Reimbursement Account. No forfeited balances are eligible for reinstatement if more than three (3) years has passed since the date of the forfeiture.

Balance in Your Supplemental Health Reimbursement Account after Your Death

If you die and you have a balance remaining in your Supplemental Health Reimbursement Account, your Dependents can continue to submit claims for reimbursement from your Supplemental Health Reimbursement Account.

10. Effective January 1, 2018, the second paragraph of the *Eligible Medical Expenses* subsection of the *Supplemental Health Reimbursement Account* section on page 54 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:

To be considered an Eligible Medical Expense, the expense cannot otherwise be reimbursed under this Plan, 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 Supplemental Health Reimbursement Account 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.

11. Effective May 22, 2018, the following is added to the end of the *No Ownership Interest* subsection of the *Supplemental Health Reimbursement Account* section on page 54, to reflect that the Fund may suspend your eligibility to receive reimbursement from your Supplemental Health Reimbursement Account 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 Supplemental Health Reimbursement Account.

12. Effective July 1, 2018, the *Required Balance* subsection of the *Supplemental Health Reimbursement Account* section on page 56 is deleted, to reflect that once Participants meet the initial eligibility requirements to receive reimbursements from their Supplemental Health Reimbursement Account, they are no longer required to maintain a minimum balance of $1,000 in their Supplemental Health Reimbursement Account in order to continue to be eligible to receive reimbursement for Eligible Medical Expenses.

13. Effective January 1, 2018, the following is added to the end of the *Supplemental Health Reimbursement Account* section on page 57, 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 from your Supplemental Health Reimbursement Account 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 Supplemental Health Reimbursement Account balance.

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

14. 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 47 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;

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	• 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

• 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.	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	• 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.

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.	
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 his or her normal nutritional requirements.	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.
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.

20667061v1

NORTHEAST CARPENTERS FUNDS
270 Motor Parkway
Hauppauge, NY 11788-5150

IMPORTANT BENEFIT INFORMATION ENCLOSED