NORTHEAST CARPENTERS HEALTH FUND

SUMMARY PLAN DESCRIPTION
For Active Participants and Retirees Located in the Following Areas of New York:

Adirondack
Buffalo
Jamestown/Olean
Niagara
Rochester
South Central
Upstate

EFFECTIVE July 1, 2017

NORTHEAST CARPENTERS HEALTH FUND

New Jersey Fund Office
91 Fieldcrest Avenue
Edison,, NJ 08818
Phone: (732) 417-3900
Fax: (732) 417-3936

Fishkill Fund Office
10 Corporate Park Drive, Suite B
Hopewell Junction, NY 12533
Phone: (845) 202-5646
Fax: (845) 897-2492

Long Island Fund Office
270 Motor Pkwy
Hauppauge, N.Y. 11788
Phone: (631) 952-9700
Fax: (631) 952-9813

Buffalo Fund Office
1159 Maryvale Drive, Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132
Fax: (716) 839-7136

Horseheads Fund Office
181 Industrial Park Road
Horseheads, NY 14845
Phone: (607) 739-1326
Fax: (607) 739-1415

Trustees as of July 1, 2017

John Ballantyne, Co-Chairman
David Haines, Vice Co-Chairman
William Banfield
Daryl Bodewes
Scott Colton
John Delsordi
Michael DeRosa
Paul Leo
Alex Lopez
Anthony Macagnone
James Malcolm
Robert Naughton
Robert Satriano
Michael Shanahan
William Sproule
Frederick Swayze, Jr.
Robert Tarby
Anthony Verrelli

John DeLollis, Co-Chairman
Jack Kocsis, Vice Co-Chairman
Robert Epifano
Glenn Garlatti
Earl R. Hall
Mark Hall
Todd Helfrich
Aaron Hilger
Eric Jensen
Brad Jorrey
James Logan
Brian McGlone
John O'Hare
F. Matthew Pepe
Robert Polisano
Adam Schmit
Alan Seidman
Brad Walters

FUND DIRECTOR
Peter Tonia

CONSULTANT
First Actuarial Consulting Team

LEGAL COUNSEL
Kroll, Heineman, Carton, LLC
Slevin & Hart, P.C.
Susanin, Widman & Brennan, P.C.

AUDITOR
Schultheis & Panettieri, C.P.A

Dear Participant:

We are pleased to provide you with this booklet that describes benefits provided by the Northeast Carpenters Health Fund ("Fund") for participants (both active and retired) in the following areas – Buffalo, Rochester, Niagara, Upstate, South Central, Adirondack and Jamestown ("Covered Areas"). This booklet describes the benefits available to you as of July 1, 2017. The Board of Trustees reserves the right, in its sole discretion, to amend this booklet at any time. This booklet provides you with an overview of the benefits available to you from the Fund. This document, together with the detailed booklets of the Fund's self-insured medical and dental benefits under the option you have chosen, issued by Excellus, is referred to as your Summary Plan Description ("SPD" or "Plan"). The rules contained in this SPD apply to claims incurred on or after July 1, 2017.

This document is both the Plan Document, and the Summary Plan Description, of the Northeast Carpenters Health Fund for participants in the Adirondack, Buffalo, Jamestown, Niagara, Rochester, South Central, and Upstate areas, for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The terms contained herein constitute the terms of the Plan.

It is important that you understand how the plan works and we encourage you to read this document carefully. You should also share it with your Dependents so that they are aware of the benefits to which they may be entitled. Certain terms used in this booklet have specific meanings with respect to your benefits. These words are capitalized and are defined in the definition section. The words "you" and "your" refer to the Participant unless the context clearly provides otherwise. Other terms used in this booklet may be defined in the Excellus booklets. Be sure to read all documentation you receive from the Fund and Excellus.

The Board of Trustees has the power to interpret, apply, construe and amend the provisions of the SPD and make factual determinations regarding its construction, interpretation and application, and any decisions made by the Board of Trustees, in good faith, are binding upon Contributing Employers, Participants, Dependents, and all other persons who may be involved with the Fund. The Trustees have contracted with Dearborn National Life Insurance Company to provide life insurance to eligible Participants. Dearborn has the authority to apply, construe, interpret and amend the life insurance policy.

It is extremely important that you keep the Fund informed of any changes in your address, marital status or desired changes to your Beneficiary designation. This is your obligation and your benefits can be delayed if you fail to provide this information in a timely manner. Please remember that no one other than the Fund Office staff can verify your eligibility for benefits. You should not rely on statements regarding benefits made by your Employer, Union agent, shop steward, supervisor or other Participants. If you have trouble understanding any part of this material or have any questions about your benefits, contact the Fund office, Monday through Friday 8:00 AM through 4:30 PM at the following offices:

<u>For participants in Buffalo, Niagara and Rochester</u>
1159 Maryvale Drive, Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132 Fax: (716) 839-7136

For participants in Adirondack, Jamestown/Olean, South Central and Upstate:
181 Industrial Park Road
Horseheads, NY 14845
Phone: (607) 739-1326 Fax: (607) 739-1415

For questions regarding the WRA, all participants should contact
the Horseheads Fund Office

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Definitions

Certain words have specific meanings with respect to the Fund. These words are capitalized throughout the SPD.

Active Participant means a Participant working in Covered Employment in a Covered Area on whose behalf contributions have been received by the Fund during the immediately preceding 6-month period. You can lose Active Participant status if your Employer is delinquent in its contributions to the Fund or if a Reciprocal Welfare Fund has not transferred contributions to the Fund on your behalf.

Contributing Employer or Employer is any employer that has signed a collective bargaining agreement with the Union or a participation agreement with the Fund that requires contributions to be made to the Fund on behalf of an Employee working in a Covered Area.

Copayment means the fixed out-of-pocket fee you pay for certain covered services.

Coinsurance generally refers to a percentage of your claim that you are required to pay out-of-pocket to a provider in addition to any required Copayment.

Covered Employment means work in a job classification for which your Contributing Employer is required to make contributions to the Fund on your behalf. If you work in employment covered by a Reciprocal Welfare Fund and your contributions to the other fund are properly transferred to this Fund, the hours you work for which contributions are made to the Reciprocal Welfare Fund will be counted as hours of Covered Employment under this Fund.

Deductible generally refers to an amount you are required to pay out-of-pocket for your medical expenses before your insurance coverage applies.

Dependent means a person who meets the requirements beginning on page 16 and as a result, is eligible for participation in the Plan.

Effective means that the SPD applies to claims incurred on or after July 1, 2017.

Eligible Medical Expenses means expenses that are tax deductible under Section 213 of the Internal Revenue Code for which you have not otherwise been reimbursed from insurance or from some other source. To be considered an Eligible Medical Expense under this Health Plan, the expense must be included in Appendix A of this SPD, as amended from time to time, and satisfy the other requirements of this SPD.

Explanation of Benefits (or Health Statement) means a document that you receive either from the Excellus or another insurance carrier under which you may be covered that explains the extent of coverage provided for a certain service or supply and the member responsibility.

Experimental means treatment that, for the particular diagnosis or treatment of the covered person's condition, is not of proven benefit or is not generally recognized by the medical community (as reflected in published medical literature). Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular

diagnosis or treatment of a covered person's condition. Any or all of the following criteria may be required to be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- There is final market approval by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met;
- Published peer-review medical literature must conclude that the technology has a definite positive effect on health outcomes;
- Published evidence must show that over time the treatment improves health outcomes (e.g., the beneficial effects outweigh any harmful effects);
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

Medically Necessary means services, supplies or durable medical equipment that are:

- Consistent with the symptoms or diagnosis and treatment of the patient’s condition, illness or injury;
- In accordance with standards of good medical practice;
- Not solely for the convenience of the patient, the family or the provider,
- Not primarily custodial,
- The most appropriate level of service that can be safely provided to the patient
- Not cosmetic, and
- Not Experimental.

The fact that a provider may have prescribed, recommended or approved a service, supply or durable medical equipment does not, in itself, make it medically necessary.

Open Enrollment Period means the period of time beginning each March 1 and ending on each March 31.

Participant means a person who works in Covered Employment for a Contributing Employer who meets the requirements for participation in the Plan as described beginning on page 11.

Reciprocal Welfare Fund means a welfare fund affiliated with the United Brotherhood of Carpenters and Joiners of America that is party to an agreement requiring that contributions made to it on behalf of participants covered by this Plan be transferred to the Northeast Carpenters Health Fund upon request of the Participant.

Union means the Northeast Regional Council of Carpenters affiliated with the United Brotherhood of Carpenters and Joiners of America, or Local Unions.

Overview of the Plan

Your Employer makes contributions to the Fund on your behalf. These contributions will be credited to a Health Reimbursement Account ("HRA") and a Wage Replacement Account ("WRA"), if applicable. The amount your Employer is required to contribute on your behalf is based on the terms of its collective bargaining agreement with the Union or its written participation agreement with the Fund. For all purposes under the SPD, your HRA and WRA will be credited only with contributions actually received on your behalf, less administrative expenses. If your employer is delinquent in its contributions to the Fund or if contributions have not been transferred from a Reciprocal Welfare Fund on your behalf, you will not be credited with those contributions, for any purpose, until they are actually received by the Fund.

Once you become eligible to seek reimbursement from your HRA (as described on page 24), you can use the balance of your HRA to pay the premiums for whichever level of health insurance you choose. You can also use your HRA balance to pay the cost of other Eligible Medical Expenses, which are described in the Section below entitled "Health Reimbursement Account." The Fund also offers a WRA for Participants in certain areas, that provides you with some income during periods of unemployment. Please refer to page 25 and review the Section entitled "Wage Replacement Account" for information about eligibility for a WRA and how you can access this benefit.

The Fund provides self-insured medical, hospital, dental and vision benefits to you and your Dependents, through an arrangement with Excellus. In addition, the Fund offers a self-insured prescription drug program through an arrangement with Express Scripts (as described beginning on page 32) and an insured life insurance benefit through Dearborn.

You will receive from the Fund a summary explaining the levels of coverage available to you for medical and dental benefits. There are three levels of health coverage from which you can choose: low (EPO D), medium (EPO B) and high (PPO) coverage. These options are described briefly beginning on page 29, and in more detail in a separate booklet prepared by Excellus. If there is any conflict between the terms of this booklet or the summary and the Excellus booklet, the terms of this booklet govern. You also have the option to elect self-insured dental coverage. Please refer to the summary to determine if you would like to elect coverage under this arrangement. Once you make an election, the Fund will provide you with a copy of the applicable booklet. Once you elect the level of your benefits, it cannot be changed until the Fund's next Open Enrollment Period.

The Fund also provides life insurance coverage to Participants through Dearborn. If there is any conflict between the terms of this booklet and the life insurance booklet, the life insurance booklet governs, except with respect to eligibility for benefits.

Except for the Fund's life insurance benefit, the Trustees have the discretion to make determinations regarding benefits offered under the Plan, including benefits available through the Fund's HRA and WRA. The Trustees also have the discretion to make determinations regarding eligibility for all benefits offered under the Plan (for example, medical/hospital, prescription drugs, dental, vision). The Trustees have the right to change, or to reduce or eliminate the benefits provided to you and your Dependents.

About Your Participation

This Section explains the rules that govern participation in the Fund.

Overview of Participation Rules

Action	Deadline
To Enroll in the Fund Coverage	45 days from the date your Health Insurance Application is sent to you.
To Self Pay Medical Premiums to the Fund Office	First day of the month for which coverage is sought
To Enroll a Dependent who lost other coverage (Except for CHIP or Medicaid)	30 days from the date coverage is lost
To Enroll a Dependent who lost coverage with CHIP or Medicaid	60 days from the date coverage is lost
To Enroll a New Dependent	30 days from the date you acquire your new Dependent.
To Elect USERRA Coverage	60 days from the date you terminated Covered Employment
To Notify the Fund of a COBRA qualifying event	60 days from the date the qualifying event occurs

When Your Participation Begins

You become a Participant in the Fund on the date your Employer begins making contributions to the Fund on your behalf. Once the Fund has received $4,000 in contributions on your behalf, you will receive an Enrollment Application ("Health Insurance Application") to enroll yourself and your eligible Dependents in one of the Fund's three benefit plans. Your medical, dental and prescription drug benefits will begin on the first day of the month after the Fund receives your completed Application. Once you are enrolled in the Fund's group health plan, contributions received by the Fund on your behalf since your participation began will be credited to the HRA on your behalf and the Fund will begin to automatically deduct the required monthly premiums for this coverage from your HRA balance. You can also use your HRA balance to reimburse the cost of Eligible Medical Expenses (described in Appendix A) incurred by you and your eligible Dependents.

You can affirmatively opt-out of the Fund's self-insured medical coverage by providing the Fund with sufficient proof that you are enrolled in another employer-sponsored group health plan with coverage that meets the minimum value standards of the Affordable Care Act ("ACA"). You must submit proof of this alternative coverage annually on a form supplied by the Fund. If you opt-out of coverage, you cannot enroll in coverage with the Fund until the next Open Enrollment Period, unless you have a special enrollment right, as described on page 17. If your Application is not received by the Fund within 45 days after it is sent to you, or if you have indicated that you are not enrolled in employer-sponsored group health coverage that meets the minimum value standard of the ACA, you and all of your Dependents identified on the HRA Enrollment Form that are not enrolled in employer-sponsored group health coverage that meets the minimum value standard of the ACA will automatically be enrolled in prescription drug coverage and the lowest level of medical coverage available to Participants in your home area. You will not be enrolled in dental coverage.

Please note: You are not eligible to receive reimbursements from the HRA until $4,000 in contributions has been received by the Fund on your behalf and you are either enrolled in the Fund's health plan with or certify that you are enrolled in another group health plan with coverage that meets the minimum value standard of the ACA.

The amount of the current required monthly premiums for coverage is noted in the summary (the "rate sheet"). The Fund's Board of Trustees has the right to change these premiums at any time. You will be notified of any such change.

Continuing Your Participation

Once you initially become eligible to receive benefits, you must maintain a $2,000 balance in your HRA at all times to continue to be eligible to seek reimbursement from your HRA for Eligible Medical Expenses. Your HRA balance can never go below $2,000, except for the reimbursement of eligible medical/dental premiums, including COBRA premiums to continue medical, dental and prescription drug coverage (see page 20). For example, if you have a $2,500 balance in your HRA and submit claims for reimbursements totaling $1,000 for non-premium related expenses, the maximum amount you can receive is $500.

Individuals that have retired from the Northeast Carpenters Pension Fund (or prior plans that merged into the Pension Fund) are not required to maintain this $2,000 minimum balance in their account. Such retirees can continue to receive reimbursements from their HRA of Eligible Medical Expenses until there is no balance remaining, subject to the other rules in the SPD.

Unless you become eligible for, and elect to receive, retiree coverage (see page 28), or are eligible to continue your benefits because of a disability (see page 14), or are eligible for, and elect to receive, COBRA coverage (see page 20), after you initially become eligible, your coverage for medical, dental, prescription drug and vision, (and life insurance, except for retirees and participants on COBRA) will continue until the earlier of the following:

- The last day of the month during which there is an insufficient balance in your HRA to pay your premiums and you do not timely self-pay the difference to the Fund;
- The last day of the month in which you are no longer an Active Participant ;
- Your death;
- The date on which the Plan is terminated; or
- The date on which the Plan is amended to no longer provide coverage to you.

Once your coverage ends, you can re-qualify for medical, dental, prescription drug, and life insurance coverage once contributions begin again on your behalf and there is a total of at least $4,000 in your HRA.

If, at any point in time, your HRA balance is not sufficient to cover your medical or dental premiums, you are required to self- pay the difference between your HRA balance and the amount of your required premiums directly to the Fund Office in order to continue your medical, dental and prescription drug coverage. Your self-pay premiums are due on the first day of the month for which this coverage is sought. If the Fund does not receive your premiums by the 5th day of each month, your coverage for these benefits will terminate retroactive to the first day of that month

(unless you are eligible for and timely elect to receive COBRA coverage) and your coverage cannot be reinstated until you re-qualify for coverage, as described on page 12. Payment is due on the first day of the month regardless of whether you receive a notice from the Fund. If you have any questions about the amount owed, it is your obligation to contact the Fund Office in advance of the date on which self-payment is due. Self-pay is not permitted if you are an owner/operator and your company is delinquent in contributions to this Fund or to the Northeast Carpenters Pension, Annuity, or Apprenticeship Training Funds.

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 either state or federal disability benefits or workers compensation benefits. However, if your HRA balance is not sufficient to cover your premiums, you will be required to self-pay the difference in order to maintain your coverage.

If your group health coverage (either with the Fund or another employer-sponsored group health plan that meets the minimum value standards of the ACA) ends, you and your eligible Dependents may continue to receive reimbursements for Eligible Medical Expenses using the balance in your HRA as of the date your group health coverage terminates. However, any contributions received on your behalf after the termination of your group health coverage will not be credited to the HRA until you enroll in the Fund's plan with or in another employer-sponsored group health plan with coverage that meets the minimum value standards of the ACA. If do not enroll in such coverage by the January 1 that is at least 36 months after the date on which contributions were received on your behalf, any such contributions will be permanently forfeited and will not be reinstated, even if you subsequently enroll in group health coverage that meets the minimum value standard of the ACA.

If you are no longer an Active Participant but continue to have a balance in your HRA, the Fund will send you an annual certification to certify that you are enrolled in an employer-sponsored group health plan with coverage that meets the minimum value standard of the ACA. It is important that you complete this form and return it to the Fund Office within 30 days of receipt. If you are not enrolled in an employer-sponsored group health plan with coverage that meets the minimum value standards of the ACA or you fail to timely return the completed certification to the Fund Office and you preform work in Covered Employment, any contributions received by the Fund on your behalf for such work will not be credited to the HRA on your behalf until you enroll in a group health plan with coverage that meets the minimum value standard of the ACA, subject to the forfeiture rules described in this SPD

Fees

The Trustees reserve the right to adjust HRA balances to reflect investment gains or losses incurred by the Fund. If the Trustees determine, in their sole discretion, that the Fund's investment performance during any period warrants, they may increase or decrease HRA balances to reflect such performance. Any increases or decreases will be reflected in your HRA balance.

In addition, if there have been no contributions to, or withdrawals from, your HRA for 12 consecutive months beginning each July 1, the Fund will automatically deduct an annual administrative fee of $120 from your HRA on the following June 30 of each year, until the earlier of:

- The date on which your HRA is forfeited (see below);
- The date on which there is no money remaining in your HRA; or
- The date on which you have any activity in your HRA (either an Employer begins making contributions again on your behalf or there is a withdrawal from your HRA).

Amounts deducted from contributions made to the Fund on your behalf or amounts deducted as an annual administrative fee will not be refunded to you even if contributions later begin again at a later date. The Fund's Board of Trustees reserves the right to change these amounts at any time. This administrative fee applies to both active participants and retirees.

Disabled Participants. If a Participant is receiving federal or state disability benefits, participation in the Plan will continue for as long as the Participant is receiving such disability benefits, provided 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. You can also continue to submit claims for the reimbursement of Eligible Medical Expenses, provided your HRA balance does not go below $2,000.

What Happens If You Return to Work in Covered Employment

If you're receiving Health Fund benefits as a Retiree receiving pension benefits from the Northeast Carpenters Pension Fund and you return to Covered Employment under the Northeast Carpenters Pension Fund that results in a suspension of your pension benefit, your Health Fund participation will continue as a Retiree until you are again eligible to be covered as an Active Employee under this Plan. Then, you will be covered as an Active Employee, except that Weekly Disability Income and Life Insurance do not apply to Retirees returning to active employment.

Disqualifying Employment

If you terminate work in Covered Employment and then return to work in Disqualifying Employment, your benefits will be suspended, as explained below. Disqualifying Employment means any employment or self-employment before age 65 in an industry covered by the Plan and in the geographic area covered by the Plan. Disqualifying Employment can be work performed for a Union or non-Union employer, whether or not the work is performed on a construction jobsite where carpenters covered under this Plan are employed, except that Disqualifying Employment shall not include any work as a supervisor, project manager or estimator for a Contributing Employer or other employer party to a collective bargaining agreement with a local union or district council of the United Brotherhood of Carpenters, Post-retirement work as a foreman will be considered Disqualifying Employment, even if performed for a union contractor. However, for purposes of the Health Fund, Disqualifying Employment does not include Covered Employment -- that is, work for which Employer contributions are due to the Health Fund on your behalf -- even if it is Disqualifying Employment under the Pension Fund and results in a suspension of your pension benefit.

Suspension of Coverage for Work in Disqualifying Employment

Your benefits will be suspended for work in Disqualifying Employment before age 65, as

explained below. However, if you return to work in Covered Employment (for which contributions are due to the Northeast Carpenters Health Fund on your behalf) your coverage will not be suspended.

Before age 62, your benefits will be suspended for any month in which you worked or were paid for more than 40 hours of service (as defined in the Pension Plan) in Disqualifying Employment. From age 62 to age 65, your benefits will be suspended for any month in which you worked or were paid for more than 40 hours of service in Disqualifying Employment after you have reached the earnings limit applicable to recipients of Social Security retirement benefits in the Plan Year. Benefits will not be suspended on and after age 65.

If you work in Disqualifying Employment as described above, then:

1. All benefits provided under this Plan will be suspended;

2. Your ability to make self-payments to continue coverage will be lost; and

3. You may not use the balance in your Health Reimbursement Account to pay for any Eligible Medical Expenses.

This means that if you work in Disqualifying Employment, you and your Dependents will not receive any benefits offered by the Fund. In addition, you will not receive any reimbursements from your Health Reimbursement Account for any reason. You are required to notify the Fund at least 10 days before you commence work in Disqualifying Employment. If you are not sure whether certain employment is Disqualifying Employment, you should contact the Fund Office. If you fail to notify the Fund of your work in Disqualifying Employment and any claims are paid, or reimbursements are made on your behalf, or on behalf of your Dependents, for services incurred while you are working in Disqualifying Employment, such payments will be treated as overpayments under the Overpayment section of this SPD and you are responsible to reimburse the Fund for the total amount paid by the Fund, to the extent permitted by law.

Reinstatement of Coverage After Disqualifying Employment

Once you terminate Disqualifying Employment, your coverage as an Active Employee will recommence on the first day of the month after $2,000 in new contributions have been received in your HRA or WRA following your cessation of Disqualifying Employment. For example, if you terminate Disqualifying Employment on August 31, 2017 and a total of $2,000 in contributions have been made into your HRA or WRA between September 1, 2017 and January 31, 2018, your benefits will recommence on February 1, 2018.

Forfeiture of HRAs and WRAs

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. HRA and WRA balances will not be reinstated, even if your Employer again makes contributions to the Fund on your behalf at a later date**.** 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.

Any Participant that has an HRA balance with the Fund can elect to permanently waive and forfeit all future reimbursements from the HRA each year during the Open Enrollment Period, and upon termination of Covered Employment, by completing a "Forfeiture Form." If you complete the Forfeiture Form during the Open Enrollment Period, your waiver will take effect January 1 of that year. In addition, you will have the right to permanently forfeit your HRA balance within 60 days of the date on which you ceased to be an Active Participant. You can request an Forfeiture Form by contacting the Fund Office. Once you complete the Forfeiture Form, any balance remaining in your HRA will be forfeited to the Fund and you cannot get that money back. If you re-enter Covered Employment after forfeiting your HRA, you will be treated as a new Participant and will need to complete a new HRA Enrollment Form.

Dependent Participation

Your eligible Dependents will be eligible for benefits under the Plan on the same day your participation begins, and their participation will continue for as long as you remain a Participant and they remain eligible Dependents. You cannot enroll Dependents unless you are participating in the Plan. You may be required to provide periodic proof that your Dependents continue to meet the requirements for coverage. Your eligible Dependents include your lawful spouse and your children, as defined below:

1. **Your lawful spouse** is the person to whom you are legally married under the laws of the state in which you reside, unless you are legally separated. If you reside in New York, you will be considered to have legally separated on the date your decree of separation is entered by a court or on the date your separation agreement is filed with a court. If you are legally separated, your spouse is not eligible for coverage under the Plan. Spouses of the same gender are considered lawful spouses for all purposes under this Plan if they were legally married under the laws of the jurisdiction in which the marriage ceremony took place.

2. **Non-Disabled Child** is your biological child, stepchild, adopted child, a child placed with you in anticipation of adoption or a child for whom you are a legal guardian. A non-disabled child is generally eligible for coverage until the last day of the month in which the child attains age 26. However, for dental benefits, coverage will end on the last day of the month in which your child attains age 19, unless your child is financially dependent on you. You will be required to complete any documentation required by the Trustees and submit proof, if requested, to prove your child's dependency as a

precondition of coverage. If your child is your financial dependent, dental coverage will end on the earlier of the last day of the month in which your child is no longer financially dependent on you or the last day of the month following your child's 26th birthday.

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

   The Board of Trustees, in its sole and absolute discretion, will determine whether a child is considered disabled under this provision.

Your Dependents will receive the same medical, dental, prescription drug and vision coverage as you. In addition, you are eligible to seek reimbursement from your HRA to cover Eligible Medical Expenses incurred by your Dependents, but only for your Dependents that are included on your HRA Enrollment Form. Unless your Dependent has a special enrollment right (as described below), Dependents can only be enrolled in the HRA program during each Open Enrollment Period. If your Dependent is enrolled in the HRA but does not enroll in Fund coverage, or does not prove that he has alternative health insurance coverage, such Dependent will automatically be enrolled in the same level of medical coverage in which you are enrolled. Your Dependents are not eligible for life insurance coverage or WRA benefits.

To be considered a Dependent, your spouse and/or child must be a citizen, national or resident of the United States, unless such individual is a resident of Mexico or Canada, except that an adopted child may still be considered a Dependent if the child has the same principal residence as the Participant and the Participant is a citizen or national of the United States.

Enrolling Dependents in Medical, Dental and Prescription Coverage. You can enroll your Dependents in Fund coverage at the same time you become eligible for benefits by including them on your Health Insurance Application. If you do not enroll your Dependents in the Fund when they first become eligible for coverage, you cannot enroll them in the Fund for any benefits until the next Open Enrollment Period, unless they become eligible for Special Enrollment (as described below).

HIPAA Notice of Special Enrollment. If you decide not to enroll yourself or your Dependents because you and/or they have other health coverage, you may be eligible to enroll yourself and/or your Dependents in Fund coverage before the next Open Enrollment Period if you and/or your Dependents lose other health coverage. You must notify the Fund Office and submit an enrollment application within 30 days after the other coverage ends. However, if you or your Dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, you must properly enroll yourself/your Dependents in Fund coverage within 60 days after coverage in Medicaid/CHIP ends

or the date you/they became eligible for the subsidy. If you properly enroll yourself and/or your Dependents within these time periods, coverage will be retroactive to the date prior coverage ended.

In addition, if you acquire a new Dependent as a result of marriage, birth, adoption or placement of a child with you for adoption, you can enroll your new Dependent retroactive to the date he/she attained dependent status as long as you notify the Fund within 30 days of the marriage, birth, adoption or placement for adoption. If not, they cannot be enrolled in Fund coverage until the next Open Enrollment Period.

When Dependent Participation Ends

Dependent coverage ends when your coverage ends or when a Dependent no longer satisfies the eligibility requirements for being a Dependent, if earlier.

- Your spouse's coverage ends on the last day of the month in which your divorce or legal separation occurs, determined under the laws of the state in which you live. If you reside in New York, you will be considered to have legally separated on the date your decree of divorce is entered by a court or on the date your separation agreement is filed with a court.

- Your child's coverage ends on the last day of the month during which your child reaches age 26, or when a disabled child age 26 or older no longer satisfies the rules for disability as described on page 17.

Qualified Medical Child Support Orders

Benefits under this Plan are not assignable to anyone other than a health care provider, except as required by law. Benefits are also not subject to the claims of a creditor and cannot be assigned by legal process except under a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a state court or agency that requires an employee to provide medical coverage under a group health plan to a child. A QMCSO usually results from a divorce or legal separation. Whenever the Fund receives a QMCSO, it will be reviewed in accordance with the Fund's QMCSO Procedures and federal law. To obtain a copy of the Fund's QMCSO Procedures, please contact the Fund Office.

Continued Coverage During a Family and Medical Leave

The Family and Medical Leave Act ("FMLA") of 1993 allows you to take unpaid leave for up to 12 weeks during any 12-month period due to:

- The birth or adoption of a child or the placement of a child with you for adoption;
- To provide care for a lawful spouse, child or parent who is seriously ill;
- Your serious illness; or
- A qualifying exigency that arises in connection with the active military service of your child, spouse, or parent. A qualifying exigency includes a) notification of military deployment within 7 days of the deployment date; b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; c) childcare and school activities, such as arranging for or providing

childcare, or attending school meetings; d) making financial and legal arrangements; e) attending counseling sessions; f) up to 5 days of rest and recuperation; g) attendance at post-deployment activities.

You may also be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service.

During FMLA leave, you can continue your coverage under this Plan provided your Contributing Employer properly notifies the Fund and makes the required payments.

Continued Coverage During Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide the right to elect continued health coverage for up to 24 months to you if you are absent from employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA. If you are absent from employment because of service in the uniformed services, you can elect to continue coverage for your eligible Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage available under USERRA begins on the date on which your absence begins and ends on the earlier of:

- The end of the 24-month period beginning on the date on which the absence begins; or
- The day after the date on which you are required to, but fail to, apply under USERRA for or return to a position of employment for which contributions must be made to the Fund.

This right to temporarily continue coverage from the Fund does not include the right to receive any life insurance or other similar non-health benefits provided under the Fund. In addition to the right to continued coverage under USERRA, you and your Dependents also may have rights to elect continuation coverage under COBRA, if they experience a qualifying event, as described beginning on page 21.

Notice and Election of USERRA Coverage. If you wish to elect USERRA coverage, you must notify the Fund Office of your absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. In addition, your election to receive USERRA coverage must be received within 60 days of the last day of Covered Employment; otherwise, you lose your right to continue your coverage under USERRA.

Paying for USERRA Coverage. You may be required to pay all or a portion of the cost of coverage. If the period of military service is less than 31 days, coverage under the Plan will continue as if you were still working in Covered Employment. If the military service extends more than 31 days, you must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. This money can be paid from your HRA, as long as there is a

sufficient balance to cover the premiums. Once you have an insufficient balance, you must self-pay the premiums in order to continue your coverage for the remainder of the USERRA period. The cost will be determined in the same manner as the cost for COBRA continuation coverage. You should contact the Fund for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if you had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date of your departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If you fail to pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is your responsibility to make timely payments. The Fund will <u>not</u> send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required payment.

When you return to Covered Employment after receiving an honorable discharge within the time periods required by law, you will be eligible to continue your coverage from the Fund. However, if there is no balance remaining in your HRA at that time, you must self-pay your premiums in order to continue your coverage.

Continued Coverage Under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health plans are required to offer temporary continuation of health coverage, on a self-pay basis, in certain situations when coverage would otherwise end. “Health coverage” includes medical, Employee Assistance Program, dental, HRA, prescription drug and vision coverage.

You need not prove that you are in good health to elect COBRA coverage, but you do need to meet the eligibility requirements and you must apply for the coverage. The Fund can terminate your COBRA coverage retroactively if you are determined to be ineligible for COBRA. The following chart shows when you and your eligible Dependents may qualify for COBRA and for how long coverage may continue. The following chart is a general summary of COBRA. You should contact the Fund Office with any questions.

For	If	Continued Coverage Maximum Period Of Coverage
You (as the employee)	When you cease to be an Active Participant for reasons other than gross misconduct	18 months*
You (as the employee)	You become ineligible for coverage due to a reduction in your employment hours	18 months*,**
Your Dependents	You die	36 months
Your spouse	You divorce or legally separate	36 months
Your Dependent children	Your dependent children no longer qualify as Dependents (for example, they reach age 26 or are no longer disabled)	36 months
Your Dependents	You become covered for Medicare benefits	36 months***

* Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage.

** For a qualified spouse or Dependent child whose continuation is due to an employee's termination of employment or reduction in employment hours, the continuation period may be extended if another qualifying event occurs during the 18-month COBRA period. Coverage may be extended for up to 36 months from the date they first qualified.

*** The employee's qualified spouse and Dependent children who are Qualified Beneficiaries (but not the employee) become entitled to COBRA coverage for a maximum period that ends 36 months after the employee becomes entitled to Medicare. This is only available where the employee had a termination of employment or reduction in hours within the 18-month period after the employee becomes entitled to Medicare.

COBRA and Medical Coverage. If you continue to receive health coverage from the Fund after experiencing a COBRA qualifying event, any such additional months of coverage will be deducted from the total number of months of COBRA you are eligible to receive. For example, assume that upon your death, your HRA balance is sufficient to cover medical premiums for your Dependents for 12 months. Assume that after those 12 months, your HRA balance is exhausted and your Dependents do not self-pay their medical premiums directly to the Fund Office. As a result, your Dependents can elect to continue their medical coverage under COBRA for a maximum of 24 months (the difference between the 36-month COBRA period and the 12 months of coverage received after your death).

COBRA and HRA Coverage. You and your Dependents also have an independent right to continue your eligibility for HRA benefits under COBRA upon the occurrence of a qualified event. For example, if you cease to be an Active Participant and before the expiration of your 18-

month COBRA period your HRA balance is exhausted, you can elect to continue your eligibility for benefits under the HRA for up to 18 months from the last day of the month that you were no longer an Active Participant, provided you pay the Fund Office the required premiums. Once the Fund Office receives your COBRA premiums, it will credit your HRA as required by law. If your HRA balance is sufficient to cover claims submitted beyond the 18 month COBRA period, eligible claims will be paid, but you will not be entitled to a COBRA election upon the exhaustion of your HRA balance.

Similarly, if you divorce, or if your Dependent children lose Dependent status under the Plan, your spouse and Dependent children, as applicable, have a right to receive benefits from the HRA for up to 36 months under COBRA, provided they pay the required COBRA premiums to the Fund.

Upon your death, your Dependents may continue seeking reimbursements from your HRA until the HRA is exhausted or until there has been 36 months of no reimbursements. If your HRA balance is exhausted within 36 months of your death, your Dependents can elect to continue coverage under the HRA under COBRA for up to 36 months from the date of your death, provided they pay the required premiums.

FMLA Leave. If you do not return to Covered Employment after your FMLA leave of absence, you become eligible for COBRA coverage as a result of your termination of employment. For the purposes of determining your eligibility for COBRA, your employment is considered terminated at the end of your FMLA leave, or the date that you notify your Employer that you will not be returning to Covered Employment.

If you marry, have a newborn child or have a child placed with you for adoption while you are covered under COBRA, you may enroll that spouse or Dependent child for coverage for the balance of your COBRA continuation period, on the same terms available to active employees. The same rules about Dependent status and qualifying changes in family status that apply to active employees will apply to you and/or your Dependent(s).

Notification of a Qualifying Event. In order to have a right to elect COBRA, you or your Dependents are responsible for notifying the Fund of your divorce or legal separation, your child losing dependent status or if you become disabled as determined by the Social Security Administration. You or your Dependents must notify the Fund Office in writing of any of these events no later than 60 days after the date the event occurs or 60 days after the date that coverage terminates under the Plan because of the event, whichever occurs later. For example, if a Participant and his spouse divorce on March 1, 2017, the Participant or spouse must notify the Fund no later than April 29, 2017 of the divorce in order for the spouse to be eligible to elect COBRA.

Your notice must include your name and the name of your Dependents who want COBRA coverage and their relationship to you, the date of your COBRA qualifying event and the qualifying event that occurred.

Although your Employer is responsible to notify the Fund of your death, termination of employment or reduction in hours of employment within 30 days of the date the event occurs, you (or your Beneficiary in the event of your death) should also notify the Fund to make sure the Fund receives timely notice. Once notified, the Fund will send you or your Dependents, as applicable,

a COBRA notice.

Making an Election. Once the Fund is notified of your COBRA qualifying event, you will receive a COBRA notice and election form. In order to elect COBRA, you or your Dependents must submit the COBRA election form to the Fund Office within 60 days after the date you lose health coverage under the Fund or 60 days from the date you receive the COBRA notice, whichever is later.

Failure to Give Timely Notice. If written notice of a qualifying event is not given within the time periods described above, and as a result, the Fund pays any premiums or self-insured claims, the Participant and any Dependents related to the Participant, are required to reimburse the Fund for any premiums or uninsured claims that should not have been paid. If the Fund is not reimbursed, all amounts due may be deducted from future benefits payable on behalf of that person or any other Dependents related to the same Participant.

Each of your eligible Dependents has an independent right to elect COBRA coverage.

Paying for COBRA coverage. If you or your Dependents elect to continue coverage, they or you must pay the full cost of the coverage elected. The first payment is due no later than 45 days after the election to receive coverage is made (and it will cover the period from the date you would lose coverage until the date of payment). Thereafter, payments are due on the first day of each month and are considered to be on time if they are made by the 30th day of each month. Costs may change from year to year.

If you fail to make the required payment, your Fund health coverage will end on the last day of the month for which payment was properly received.

What COBRA coverage provides. COBRA continuation coverage generally is identical to the current coverage the Plan provides for similarly situated employees or family members, except life insurance, WRA benefits are not available under COBRA. Participants and Dependents who elect COBRA to continue coverage under the HRA will be able to submit claims up to the balance of the HRA at the time the COBRA qualifying event occurs, reduced by any expenses that are incurred before the date of the qualifying event (but reimbursed after that date) on behalf of the person electing COBRA. In addition, Participants and Dependents will receive annual additions to their HRA in the same manner as similarly situated active Participants. If, during the period of COBRA continuation coverage, the Plan's benefits change for active employees, the same changes will apply to COBRA participants.

When COBRA coverage ends. COBRA coverage ordinarily ends at the end of the maximum coverage period specified in the chart on page 21. It will stop *before* the end of the maximum period under any of the following circumstances:

- failure to make the required payments on a timely basis; or
- a COBRA participant becomes covered under Medicare or another group plan.

Once COBRA coverage terminates, it cannot be reinstated unless otherwise permitted by law.

Health Reimbursement Account

Once $4,000 in contributions is received by the Fund on your behalf, the Fund will establish an HRA in your name, provided you are enrolled in a group health plan with coverage that meets the minimum value standards of the ACA. To the extent permitted by law, contributions received on your behalf will be credited to the HRA, an amount as determined by the Fund's Board of Trustees in its sole and absolute discretion for administrative expenses. The cost of your medical/dental premiums and the cost of all other self-insured benefit provided by the Fund will be deducted from the HRA. The Fund has the right to modify the premiums deducted from your HRA balance for coverage under the Fund's medical/dental plan at any time.

In addition, once your initial HRA balance reaches $4,000, your HRA can be used to reimburse you for Eligible Medical Expenses. (Amounts deducted from contributions made on your behalf for administrative expenses, and investment gains and losses are not included to determine compliance with required minimum balances.) 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. In addition, unless otherwise specified in Appendix A, an expense is not an Eligible Medical Expenses if it is otherwise excluded from coverage under the terms of this Plan. The Fund will not reimburse any expenses that are not Medically Necessary, including but not limited to services that are Experimental or cosmetic.

If your Employer is delinquent in its contributions to the Fund and as a result, you have an insufficient balance in your HRA to cover your medical premiums, you must self-pay the required premiums to the Fund in order to continue your medical, dental and prescription drug coverage. If the Fund later recovers the delinquent amount owed from your Employer, you can submit a request to the Fund for reimbursement from your HRA of the premiums you self-paid as a result of the delinquency, provided your request for reimbursement is received within one year of the date self-payment is made. The Fund will not reimburse you for any premiums if such reimbursement would cause your HRA balance to be less than $2,000.

You have no ownership interest in your HRA. Under federal law, you are not entitled to receive any money from your HRA except to pay premiums or reimbursement of Eligible Medical Expenses as approved by the Fund. The Fund has a right to deny your request for reimbursement from your HRA if the submitted expense is not permitted under the Plan.

The Fund has a right in its sole discretion to determine whether an expense is eligible for reimbursement from your HRA. A determination as to whether an expense is reimbursable will not be made until you have already paid for the supplies and/or services. As noted in Appendix A, certain expenses (e.g., durable medical equipment) require both a physician's prescription and a letter of medical necessity. The prescription must indicate the specific medical condition that the durable medical equipment is intended to treat. The letter of medical necessity must explain why the durable medical equipment is necessary and indicate the anticipated medical outcome. A letter of medical necessity is considered valid for 12 months from the date it is written by a physician. No Participant or Dependent can elect to receive cash or other taxable or non-taxable benefit from their HRA other than for the reimbursement of Eligible Medical Expenses.

To be eligible for reimbursement, a claim must be <u>received</u> by the Fund Office within 12 months of the date on which the expense was incurred. If a claim is received after the expiration of this 12 month period, your request for reimbursement will be denied. In general, the minimum

allowable reimbursement is $100. Therefore, expenses should not be submitted until, when added together, they total at least $100. However, each January and July you may seek reimbursement of Eligible Medical Expenses that are less than $100. In addition, you are limited to one submission of claims for each calendar month. However, you can submit as many claims as you want with each submission. For example, if you submit 6 claims for Eligible Medical Expenses on March 5, 2017, you are not entitled to submit claims again until April 1, 2017. If you submit a claim on March 21, 2017 instead of waiting until April 1, 2017, your claim will be denied as ineligible for reimbursement at that time. For all purposes, a claim is considered submitted to the Fund on the date it is received in the Fund Office.

Under no circumstances can you receive reimbursement for expenses that were incurred before the date you became a Participant in the Plan. All claims must be submitted in writing and include substantiation satisfactory to the Fund, that the expenses have been incurred and paid by you or your Dependent, and the amount of the charge. You must also confirm that the expenses have not been reimbursed and are not reimbursable under any other medical plan that provides health coverage. For doctor or hospital expenses or medical supplies, you must submit a statement from your insurance company (Explanation of Benefits) showing the expenses incurred and the balance owed. Please review Appendix A to determine exactly what documentation you are required to submit for each type of claim. If you are required to submit a receipt, such as from a doctor or pharmacy, you must submit the original receipt or a clearly legible photocopy. The Fund reserves the right to request the original receipt. If you submit a photocopy, the Fund Office reserves the right to request the original receipt as well. In addition, the Fund will not return any documents to you. You should make copies for your records. Payments will generally be made directly to you or your Dependents, not to providers or suppliers. However, if a claim is for $600 or more to a single provider, you can request that the Fund pay the provider directly, by contacting the Fund Office and submitting a Claims Assignment Form and an IRS Form W-9 signed by the provider.

If there is a balance in your HRA at the time of your death, your Dependents may continue to submit claims to the Fund for Eligible Medical Expenses they incur provided that your dependent children satisfy the age requirements as described on page 17. However, if there are no reimbursements made from your HRA during any 36 month period following your death, your HRA will be forfeited and used for Fund administrative expenses consistent with the forfeiture rules described on page 16. Your Dependents can also use your HRA to pay for their COBRA premiums following your death. If there is an insufficient balance in your HRA to cover their COBRA premiums, your Dependents can continue their coverage by self-paying their COBRA premiums to the Fund.

Wage Replacement Account

For participants in the Buffalo, Jamestown/Olean, Niagara and Rochester areas (Local Union 276), once your HRA balance reaches $10,000, a Wage Replacement Account ("WRA") will be established in your name as of the next January 1 or July 1. Once a WRA has been established for you, the following rules apply:

- If you are enrolled in family health coverage or two person coverage with the Fund, 80% of your Employer's contributions will be credited to your HRA and 20% will be credited to your WRA, after deducting applicable administrative expenses.

- If you are enrolled in individual coverage with the Fund or if you opt out of the Fund's health coverage, 80% of your Employer's contributions will be credited to your WRA and 20% will be credited to your HRA, after deducting applicable administrative expenses.
- If your HRA balance falls below $10,000 on January 1 or July 1, when the allocations are determined, 100% of future Employer contributions will be allocated to your HRA.
- If you are at least age 55 on January 1 or July 1, but not yet age 62, and the balance of your WRA is at least $10,000 on January 1 or July 1, no additional amounts will be allocated to your WRA and 100% of future Employer contributions (after deducting applicable administrative expenses) will be allocated to your HRA.
- If you are at least age 62 on January 1 or July 1, 100% of your future Employer contributions (after deducting applicable administrative expenses) will be allocated to your HRA, regardless of the balance of your WRA.
- In addition, regardless of age, if your WRA balance is $15,000 or more, as of the next January 1 or July 1, 100% of your contributions (after deducting applicable administrative expenses) will be allocated to your HRA.

In no event will a Participant receive benefits in excess of the balance remaining in his WRA at any time.

Upon your retirement and receipt of benefits from the Northeast Carpenters Pension Fund, your death, or following 36 consecutive months of no activity (no contributions credited to your HRA or WRA and no withdrawals made from your HRA or WRA), any balance remaining in your WRA will be forfeited to the Fund and used for Fund administrative expenses. For all purposes under this section of the SPD and the HRA Section on page 24, benefits will be deemed paid in the year in which a check is issued by the Fund, and not the year in which the expense is incurred or the application for reimbursement is received.

All benefits paid from your WRA are subject to state and federal income tax and such taxes will be deducted from your WRA. In addition, employer FICA and FUTA taxes imposed on your WRA benefits will be deducted from your WRA. When you apply for a benefit, the Fund will automatically withhold such taxes from your payments and pay them over to the appropriate taxing authority. If you have any questions regarding the tax implications of receiving benefits from your WRA, you should contact your tax advisor.

Wage Replacement. Your WRA provides you with income in the event you are out of work for unemployment, workers compensation, or disability, consistent with the requirements of this section of the SPD.

- **State Unemployment Benefit.** You are eligible to receive up to $525 (after taxes) for each week you are receiving State unemployment compensation. Your signed Fund application for WRA withdrawal must be accompanied by a State Unemployment payment history which should include the participants name and Social Security Number.

  An additional supplemental unemployment benefit is payable to you after you have withdrawn 2 consecutive weekly payments from your WRA because of unemployment. If you are eligible for this supplemental unemployment benefit, you can elect to withdraw up to 25% of your WRA account balance (not to exceed $3,000) for your next weekly payment. This special 25% withdrawal can only be made once each calendar quarter,

which would allow you up to 4 withdrawals in a calendar year.

Application forms are available from the Fund Office. Applications for WRA benefits must be received within 90 days after the end of the calendar year in which you became eligible for the benefit.

- **Workers' Compensation Benefit.** You are eligible to receive up to $600 for each week you are receiving workers' compensation benefits. Your signed Fund application for WRA withdrawal must be accompanied by workers' compensation pay stubs. Application forms are available from the Fund Office. Applications for WRA benefits must be received within 90 days after the end of the calendar year in which you became eligible for the benefit.

- **New York State Disability Insurance Benefit.** You are eligible to receive up to $1,000 (after taxes) for each week you are receiving New York State Disability Insurance. Your signed Fund application for WRA withdrawal must be accompanied by Disability pay stubs. Application forms are available from the Fund Office. Applications for WRA benefits must be received within 90 days after the end of the calendar year in which you became eligible for the benefit.

Time Loss Benefit. The Fund also offers a time-loss benefit from your WRA. This benefit is available if you are out of work and not eligible for State unemployment, workers compensation or disability benefits, provided that you are properly registered on your local Union's or Council's "out of work" list. You will receive up to $1,000 per week (after taxes) from your WRA. You must submit a completed application form to the Fund Office along with a written certification that you are unemployed and available for work in Covered Employment on the Union's out-of-work list for the full week(s) for which you are claiming benefits (Monday through Friday). You must also submit evidence that your unemployment or Workers' Compensation benefits have been exhausted. The Fund may also require periodic proof from your local Union or Council that you are registered on the "out-of-work" list. Applications must be received within 90 days after the end of the calendar year in which you became eligible for this benefit. Application forms are available from the Fund Office.

Dependent Care and Elder Care. You can withdraw money from your WRA to reimburse you for expenses that you incur to provide care to your eligible dependents while you and your spouse are at work. In order to be eligible for reimbursement, the individual receiving the care must be declared as your dependent on your federal income tax return. Claims for dependent or elder care reimbursement must be accompanied by a paid receipt listing dates your dependents were cared for, the name of the provider and the provider's tax identification number, social security number or facility license number. The maximum benefit you are entitled to receive is $5,000.00 per calendar year. You are encouraged to submit your claims as soon as possible to avoid missing the claims deadline, which is one year after the expense was incurred. A claim that is not submitted within this one-year period will be denied as untimely.

Special Coverage Information

Coverage Under the Newborns' and Mothers' Act

Under federal law, group health plans and health insurers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Fund may not require that a provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage Under the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, the Plan is required to provide certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician for:

- all stages of reconstruction of the breast on which the mastectomy was preformed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis; and
- treatment of physical complications or the mastectomy, including lympedemas.

Such benefits are subject to the Fund's co-insurance and deductible provisions.

Retiree Coverage

If you have retired and are receiving benefits under the Northeast Carpenters Pension Fund (or any prior plan that merged into the Pension Fund), you are eligible for the following:

Retirees, spouses, and dependent children not eligible for Medicare. You are eligible to receive health benefits from the Fund under the same programs available to actively employed participants. You can use any balance in your HRA to pay the required premiums. The $2,000 minimum balance requirement described on page 12 does not apply to retirees. If you have no balance remaining, you can continue your coverage as long as you timely self-pay these premiums to the Fund Office each month. Retirees can also seek reimbursement from their HRAs for Eligible Medical Expenses. The 36-month forfeiture rule described on page 16 does not apply to retirees.

If you are a non-Medicare eligible retiree and you opt-out of medical coverage, you can re-enroll in coverage during a subsequent Open Enrollment Period, provided you submit evidence that you had other employer-sponsored health coverage during the entire time you were not enrolled in the Fund's medical coverage.

Medicare-Eligible Retirees and spouses. You can use any balance remaining in your HRA to reimburse any Medical Eligible Expenses listed in Appendix A. However, you are not eligible to continue in the Fund's medical, dental, 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.

Overview of Your Health Fund Benefits

The charts below list the different benefits available under the Plan and the eligibility rules for each type of benefit. It also advises of your out of pocket costs, if any, for these benefits and any limits that apply. The following benefits apply only to active participants and non-Medicare eligible retirees.

Please note that for Out-Of-Network Benefits, you are responsible to pay any amount charged by your Provider that exceeds the reasonable and customary charges for the services rendered, in addition to any Co-Insurance, Deducible and Co-payments that are required under the Plan.

The Plan offers three different levels or options for medical benefits – High (PPO J), Medium (EPO B), and Low (EPO D). The following is a very brief description of the benefits in each option. Please review the Excellus booklet for the details of the option you have chosen, including services covered, copays, coinsurance, limits (such as the number of visits or days covered), and exclusions.

BENEFITS			
Benefit	**How It Works In General**	**Who's Eligible**	
		EMPLOYEES AND NON-MEDICARE RETIREES	**DEPENDENTS**
Medical, including hospitalization, major medical, Doctor treatment, preventive care, mental health care, hospice, home care, maternity, medical equipment, chiropractic treatment (see Excellus booklet for details).	**High Option (PPO-J)** When you go to an In-Network provider for your care, the Plan pays 100% of the reasonable and customary charges for hospital care. After a $20-per-visit copayment, the Plan pays 100% of reasonable and customary charges for most other eligible medical expenses (subject to Plan limits). For emergency room visits, you are required to pay a $100 per-visit co-payment. Your out-of-pocket in-network expenses are capped at $3,000/individual and $6,000/family per year for medical expenses. When you go to an Out-of-Network provider for your care, the Plan pays 70% of the reasonable and customary charge for hospital care and after a $750/individual or $2,250/family annual deductible, the Plan pays 70% of the reasonable and customary charge for most other eligible medical expenses (subject to Plan limits). Your 30% share is capped at $4,200/individual or $12,600/family per year. Hospital Emergency treatment is provided on an in-network basis.	Yes	Yes

	Medium Option (EPO B) When you go to an In-Network provider for your care, after a $250/individual and $750/family annual deductible, the Plan pays 80% of the reasonable and customary charges for hospital care. After the annual deductible and a $25-$35 per-visit copayment, the Plan pays 80% of the reasonable and customary charges for most other eligible medical expenses (subject to Plan limits). For emergency room visits, you are required to pay a $100 per-visit co-payment after the deductible. Your out-of-pocket in-network expenses are capped at $1,000/individual and $3,000/family per year for medical expenses. Out-of-network services are not covered.	Yes	Yes
	Low Option (EPO D) When you go to an In-Network provider for your care, after a $1,000/individual and $3,000/family annual deductible, the Plan pays 80% of the reasonable and customary charges for hospital care. After the annual deductible and a $25-$40 per-visit copayment, the Plan pays 80% of the reasonable and customary charges for most other eligible medical expenses (subject to Plan limits). For emergency room visits, you are required to pay a $100 per-visit co-payment after the deductible. Out-of-network services are not covered. Your out-of-pocket in-network expenses are capped at $2,000/individual and $6,000/family per year for medical expenses. Out-of-	Yes	Yes
Prescription Drugs	**High, Medium and Low Options:** Your out-of-pocket in-network expenses for prescription drugs are capped at $3,600 individual, $7,200 family per year. **Retail** When you fill your prescriptions at a participating retail pharmacy, you pay a $9.00 copay for generic prescription, 20% coinsurance for brand name prescription, and 20% coinsurance for specialty drugs through Accredo. You can get up to a 34-day or 100-dose supply per prescription, whichever is less.	Yes	Yes
	Mail Order When you fill your prescriptions through the Mail Order Program, you pay a $22.50 copay for generic prescriptions, 20% coinsurance for brand name prescriptions, and 20% coinsurance for specialty drugs through Accredo. You can get up to a 90-day supply per prescription.	Yes	Yes
Dental (See Excellus booklet for details)	For an additional premium, you can elect self-insured dental coverage through Excellus. The Plan pays 100% for in-network preventive care. After an annual deductible of $25/individual and $75/family, the Plan pays 80% for basic services and 60% for major services, subject to a $1,000 annual maximum/individual. After the annual deductible, the Plan pays 50% for orthodontic treatment, subject to a $500 annual maximum and $1,000 lifetime maximum/individual.	Yes	Yes

Vision	**High, Medium and Low Options:** After a $20 copayment under the High and Medium Options ($40 under the Low Option), the Plan pays 100% of allowable expenses for an eye exam every two years, and frames and contact lenses every 2 years up to a maximum of $240.	Yes	Yes
Life Insurance	$30,000 of life insurance provided to active participants by Dearborn is payable to your beneficiary upon your death, subject to the terms of the policy.	Yes	No

Annual Out-of-Pocket Maximums.

The Plan limits the amount of money that you can be required to pay out of pocket during a 12-month period for Co-payments, Co-insurance and Deductibles. This is referred to as an "out-of-pocket maximum." The in-network out-of-pocket maximum for the period April 1 through March 31, is:

For the PPO J plan:

- For in-network medical benefits: $3,000 per individual and $6,000 per family.
- For out-of-network medical benefits: $4,200 per individual and $12,600 per family.
- For prescription drug benefits: $3,600 per individual and $7,200 per family.

For the EPO B plan:

- For in-network medical benefits: $1,000 per individual and $3,000 per family.
- For prescription drug benefits: $3,600 per individual and $7,200 per family.

For the EPO D plan:

- For in-network medical benefits: $2,000 per individual and $6,000 per family.
- For prescription drug benefits: $3,600 per individual and $7,200 per family.

Once an individual or family reaches these out-of-pocket maximums, no Co-payments, Co-insurance or Deductible (if applicable) will be required to be paid for the remainder of the 12-month period. Please note that not all out-of-pocket expenses count towards this maximum. For example, any penalty you pay for failure to pre-certify a service or treatment that requires pre-certification will not be counted towards these limits, nor will any amounts you pay for anything that is excluded from coverage under the Plan.

Prescription Drug Benefits

The Fund offers prescription drug benefits through a self-insured arrangement with Express Scripts. The list of prescription drugs that are covered by the Plan is known as a "formulary." The Plan's formulary includes a wide selection of generic and brand-name medications. You can get a copy of the applicable formulary by contacting Express Scripts at 1-800-849-9036.

There are two ways to fill prescriptions:

At Participating Retail Pharmacies

To have your prescription filled at a retail pharmacy, go to a pharmacy that participates in the Express Scripts retail network with your prescription and your prescription ID card. All prescriptions filled at a participating retail pharmacy can be written to provide for up to a 34-day supply.

Your Co-payment is:

- $9 if the prescription or refill is filled with generic drugs,
- 20% coinsurance if it is filled with brand-name drugs;
- 20% coinsurance if it is filled with specialty drugs (including specialty generic) through Accredo.

You are not required to satisfy any deductible and there are no claim forms to complete. If your doctor prescribes a formulary brand-name drug, your prescription will be filled with an "A" rated generic drug unless a generic form is not available or your doctor writes "DAW" (dispense as written) on your prescription. A generic drug has the identical chemical composition of a brand-name drug.

Coinsurance is a percentage of the drug's cost. To check the cost for any of your covered drugs, log in at express-scripts.com and choose "Price a medication" from the menu under "Manage Prescriptions." You can also call Accredo, an Express Scripts specialty pharmacy, at 1-800-849-9036 for questions about specialty drug costs or to order a specialty drug.

If you fill your prescription at a pharmacy that does not participate in the Express Scripts network, you will be required pay the entire cost of your prescription drug. You may then submit a written request to Express Scripts for reimbursement or call them at 1-800-849-9036. If your prescription is for a drug that is covered under the Plan, Express Scripts will reimburse you for the Plan's discounted rate less any applicable copay.

You will pay more for your long-term maintenance drugs (such as those used to treat high blood pressure or high cholesterol) unless you order your prescriptions through the mail by using the Express Scripts Pharmacy. The first three times that you purchase a long-term maintenance drug at a participating retail pharmacy, you'll pay your retail co-payment. After the third purchase, you'll pay the entire cost if you continue to fill your prescription for maintenance drugs at retail. To avoid paying more, use the Express Scripts Pharmacy and pay your mail- order co-payment for up to a 90-day supply.

Using the Mail Order Pharmacy

The Express Scripts mail order program is designed for those who take maintenance drugs (medication taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma). For up to a 90-day supply of a covered medication, participants pay a Co-payment of:

- $22.50 if the prescription or refill is filled with generic drugs;
- 20% coinsurance if it is filled with brand-name drugs;
- 20% coinsurance if it is filled with specialty drugs (including specialty generic) through Accredo.

There are two ways to submit mail-order prescriptions through the Express Scripts Pharmacy:

By mail –

- Ask your doctor to write a prescription for up to a 90-day supply, plus refills for one year, as appropriate. (If you need a supply of the medication while you wait for your mail order to arrive, ask the doctor for 2 two prescriptions: one for a 30-day supply to be filled at a participating retail pharmacy, and the other for up to a 90-day supply to send to the Express Scripts Pharmacy.)

- Mail the prescription, a completed mail-order form, and your payment to the Express Scripts Pharmacy at the address on the form. Be sure to fill in all areas of the form, including the member ID number shown on your prescription drug card.

By fax –

- Ask your doctor to call 1-888-327-9791 for instructions on faxing the prescription to the Express Scripts Pharmacy. Provide him or her with your member ID number, which is needed to complete the transaction. (Only doctors can fax prescriptions to Express Scripts.)

You can pay by e-check, credit card, check, or money order. Standard shipping is free. Expedited shipping is available for an extra charge. Orders usually ship within 8 days after Express Scripts receives your prescription.

To obtain extra order forms, physician fax forms, or return envelopes, visit www.expressscripts.com and click "Forms & Cards" under "Prescriptions & Benefits" on the left side of the screen. You can also order forms and envelopes by calling Express Scripts Member Services at 1-800-849-9036. (If you're a first-time visitor to the Express Scripts website, please take a moment to register using your member ID number and a recent prescription number.)

Please note: Certain drugs that are included in the preventive care recommendations from the U.S. Preventive Services Task Force with a rating of A or B are covered by the Fund with no cost-sharing (co-pay). In addition, drugs included in the comprehensive guidelines on preventive care for women supported by the Health resources and Services Administration will also be available with no out of pocket expenses. However, for both these changes, drugs will be paid with no cost-sharing only to the extent required by law and subject to certain age, gender, and other reasonable medical management limitations. For example, oral contraceptives in generic form will be covered at no cost to you, but if you choose a brand name contraceptive for which a generic form is available, you will still have to pay the applicable Plan coinsurance for brand drugs, unless it is medically inappropriate for you to take the generic form. If you have questions about whether you are eligible to receive certain prescription drugs without any co-

payment, please call Express Scripts at 1-800-849-9036.

Certain specialty drugs require pre-authorization from Accredo Specialty Pharmacy before the Fund will provide coverage. You will receive additional correspondence from Accredo about the pre-authorization process and a list of specialty drugs for which pre-authorization is required. Once you receive a prescription for a specialty drug, you should contact Accredo co immediately at 1-800-803-2523. Accredo will review your medical history and consult with the prescribing doctor to ensure that the drug being prescribed in appropriate for your medical condition. In some cases, after consulting with your doctor, Accredo may authorize a preferred specialty drug as an alternative to a prescribed non-preferred specialty drug. However, Accredo will never change the prescription without the approval of the prescribing doctor. Once the drug has been pre-authorized, it will be covered by the Fund consistent with the terms of this SPD. If Accredo does not pre-approve the drug, the Fund will not provide coverage. You have the right to appeal a pre-authorization denial consistent with the Fund's claims and appeals procedures.

If you fail to seek pre-authorization for a drug before you submit the prescription to the pharmacy, the pharmacist will advise you that you need to contact Accredo for pre-approval before coverage under the Plan is available.

Eligible Drugs

The following drugs are covered under the Plan:

- federal legend prescription drugs;
- drugs requiring a prescription under the applicable state law;
- oral contraceptives for participant and spouse, and dependent children to the extent required by law;
- vitamins with a prescription or to the extent required by law;
- pre-natal vitamins requiring a prescription;
- diabetic test strips.

Ineligible Drugs

The following drugs are not covered under the Plan:

- drugs that are not Medically Necessary
- non-legend drugs;
- therapeutic devices or appliances, support garments and other non-medical substances;
- drugs intended for use in a Doctor's office or another setting other than home use;
- investigational or Experimental drugs, including compounded medications for non-FDA approved use;
- prescriptions that a covered person is entitled to receive without charge under any workers' compensation law, or any municipal, state, or federal program;
- dietary supplements;
- fertility medications;
- anorexiants;
- Retin-A (age 26 and over);
- growth hormones (unless prior authorization from the Fund is obtained)
- Substance abuse agents limited by federal laws governing controlled substances

Dental

The Fund offers optional self-insured dental benefits through an arrangement with Excellus. Generally, for in-network providers, the Fund pays 100% of preventive care. After the annual deductible of $25/individual and $75/family, the Plan pays 80% for basic services and 60% for major services, subject to a $1,000 annual maximum/individual. After the deductible, the Plan pays 50% for orthodontic treatment, subject to a $500 annual maximum and $1,000 lifetime maximum/individual. The Fund pays the same amount to out-of-network dental providers. However, the provider is not obligated to accept the Fund's payment as payment in full and you may be responsible for paying the balance of the provider's billed fee ("balance billing").

See the Excellus dental booklet for more information.

Vision

The Plan will provide coverage for an exam and frames and contact lenses once every two years, based on the date of service. The eye wear must be prescribed by an optometrist or ophthalmologist; however, benefits will not be provided for sunglasses, even if ordered by your optometrist or ophthalmologist. Coverage will not be provided under the Plan for eye wear required by your employer as a condition of employment, or rendered through a medical department, clinic, or similar service provided or maintained by the employer.

In-Network. After a $20 copayment under the High and Medium Options ($40 under the Low Option), In-Network Benefits are covered at 100% of the allowable expense. For frames and contact lenses, there is a maximum of $240 per person every two years.

Out-of-Network. Out-of-Network Benefits are covered the same as In-Network Benefits. However, the provider may bill you for the balance of allowed charges not covered by the Plan.

Life Insurance Benefits

Your life insurance benefits are insured by Dearborn National Life Insurance Company. You will be provided with a separate booklet, prepared by Dearborn, that provides detailed information about this benefit, including filing claims and appeals and designating a beneficiary. If you have questions about your coverage, please contact Dearborn at 1-800-348-4512. The information noted below is only a summary of your benefits. If there is any conflict between these provisions and the Dearborn booklet, the terms of the Dearborn booklet will govern.

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.

Subrogation and Reimbursement

If you or your Dependents are injured as a result of negligence or other wrongful acts and you and/or your Dependents apply to the Fund for benefits and receive such benefits, the Fund shall have a first priority lien for the full amount of those benefits against any recovery you receive from any third party that caused, contributed to, or aggravated your injuries or from any other source responsible for payment thereof related to such an accident. This is referred to the Fund's right of reimbursement and subrogation.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay your (or your eligible dependent's) benefits based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. The Fund advances benefits to you and your dependents only as a service to you. You must reimburse the Fund if you obtain any recovery from another person or entity.

You and/or your dependent are required to notify the Fund within ten days of any accident or Injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit or settlement negotiations arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims.

If you or your dependent receive any benefit payments from the Fund for any Injury or Sickness, and you or your dependent recover any amount from any third party or parties in connection with such Injury or Sickness, you or your dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your dependent's behalf in connection with such Injury or Sickness.

Also, if you or your dependent receive any benefit payments from the Fund for any Injury or Sickness, the Fund is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such Injury or Sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Sickness in your or your dependent's name and also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier under any self-insured or underinsured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury or Sickness, and regardless of whether you and/or your dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's right of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the Injury and Sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your dependent's own self-insured motorist

insurance, under insured motorist insurance, or any medical pay or no fault benefits payable. The "make-whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in this section, if you or your dependent submit claims for or receive any benefit payments from the Fund for an Injury or Sickness that may give rise to any claim against any third party, you and/or your dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Subrogation Agreement must also be executed by your or your dependent's attorney, if applicable. Alternatively, if you or your dependent or a representative of you or your dependent (including your or your dependent's attorney) fail or refuse to execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your dependent recovers from a third party.

Any refusal by you or your dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery your receive, no matter how characterized, up to the full amount paid by the Fund on your or your dependent's behalf relating to the applicable Accident or Injury will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or

on behalf of, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident or Injury, no matter how these amounts are characterized or who pays these amounts, as provided in this Section.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. You or your dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you or your eligible dependent chooses not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your dependent waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, deducting the amount owed from your HRA or offsetting the amounts paid against your and/or your dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays for your or your dependent's injuries.

Fraud

The Board of Trustees reserves the right to cancel or rescind Fund coverage for any Participant or Dependent who willfully and knowingly engages in any activity intended to defraud the Plan. If a claim has been submitted for payment or paid by the Fund as a result of fraudulent representations, such as enrolling a dependent who is not eligible for coverage or continuing coverage for a spouse after a divorce or legal separation, the Fund will seek reimbursement and may elect to pursue the matter by pressing criminal charges.

The Fund must be advised of any discounts or price adjustments made to you by any Provider. A Provider who waives or refunds a Co-payment is entering into a discount arrangement with you. The Fund calculates benefit payments based on the amount actually charged, less any discounts, rebates, waiver or refunds of Co-payments or Deductibles. Failure to notify the Fund of such Provider adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan.

Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in dependent status or accepting benefits in excess of what is covered under the Plan, will be considered fraud.

Overpayments

If the Fund pays benefits in error, such as when the Fund pays you or your dependent more benefits than you are entitled to, or if the Fund advances benefits that you or your dependent are required to reimburse because, for example, you have received a third party recovery (see the Subrogation Section of this SPD), you are required to reimburse the Fund in full and the Fund shall be entitled to recover such benefits.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your dependent to reimburse the Fund for an overpaid amount will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your dependent refuse to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by methods which include, but are not necessarily limited to,

deducting the amount owed from your HRA or offsetting the amounts paid against your and/or your dependents' future benefit payments under the Plan. For example, if the overpayment or advancement was made to you as the Fund participant, the Fund may offset the future benefits payable by the Fund to you and your dependents. If the overpayment or advancement was made to your dependent, the Fund may offset the future benefits payable by the Fund to you and your dependents.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

Incompetence

In the event it is determined by the Fund's Board of Trustees that someone who is entitled to benefits is unable to care for his affairs because of illness, accident or incapacity, either mental or physical, any payment due may, unless the claim has been made by a duly appointed guardian, committee or other legal representative, be paid to the individual's spouse or other person having care and custody of the claimant or such person having the claimant's power of attorney, as the Board of Trustees will determine in its sole discretion.

Cooperation

Every claimant is required to furnish to the Board of Trustees all such information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Fund. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment of benefits. The Board of Trustees will be the sole judge of the standard of proof required in any case, and may from time to time adopt such formula, methods and procedures as the Board considers reasonable.

Mailing Address

In the event that a claimant fails to inform the Board of Trustees of a change of address and the Board is therefore unable to communicate with the claimant at the address last recorded and a letter sent by first class mail to such claimant is returned, payments due the claimant will be held without interest until payment is successfully made.

Claims and Appeals Procedures

Claims For Benefits

All claims for self-insured benefits, such as medical, dental and vision claims, prescription drug claims, and HRA and WRA reimbursements, must be submitted as shown below. You can obtain a claim form for HRA and WRA claims from the Fund Office.

You are encouraged to submit your claims as soon as possible to avoid missing the claims deadline, which is one year after the expense was incurred (unless noted otherwise in this SPD). Any claims that are not submitted within this one-year period will be denied as untimely.

How to File Claims

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

Medical, Dental and Vision Claims
Excellus BlueCross/Blue Shield
Advocacy Department
PO Box 4717
Syracuse, NY 13221
Fax: (315) 671-6656

Prescription Drug Claims
Express Scripts
Prior Authorization Dept.
PO Box 66571
St. Louis, MO 63166-6571

HRA

For participants in Buffalo, Niagara and Rochester

Northeast Carpenters Health Fund
1159 Maryvale Drive, Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132 Fax: (716) 839-7136

For participants in Adirondack, Jamestown/Olean, South Centra and Upstate

Northeast Carpenters Health Fund
181 Industrial Park Road
Horseheads, NY 14845
Phone: (607) 739-1326 Fax: (607) 739-1415

WRA claims should be submitted to the Horseheads Fund Office

The following are not considered claims for benefits:

- Inquiries about Plan provisions or eligibility rules that are unrelated to any specific benefits claims;
- A request for prior approval of a benefit that does not require prior approval by the Fund;

For information on filing a claim or appeal for life insurance, review the Dearborn booklet.

Claim Forms

All claim forms must be properly completed and include the following information to be considered a valid claim:

- Participant name;
- Patient name;
- Patient Date of Birth;
- Social Security Number of Participant;
- Date of Service;
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition**,** as maintained and distributed by the American Medical Association);
- ICD-10 (the diagnosis code found in the International Classification of Diseases, 10th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of Units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address of the prior order;
- Details of any accident that may have caused your injuries and signed subrogation agreement;
- Information about any other coverage that the patient has.

Authorized Representatives

You may appoint an authorized representative to take action on your behalf, such as completing claims forms. To do so, you must notify the appropriate claims-processing entity and the Fund Office in writing of the representative's name, address, and telephone number and authorize the release of information (which may include medical information) to your representative. You may be required to provide additional information to verify that your representative is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim without you having to complete an authorization form.

Reviewing Claims

In making decisions on claims and appeals, the appropriate claims-processing entity will apply the terms of the Plan document and any applicable guidelines, rules and schedules. The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending

upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

Pre-Service Claims

A Pre-Service Claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the approval of the benefits before you receive the medical care. You will be notified of a decision on your Pre-Service Claim (whether approved or denied) within 15 days of the receipt of a properly completed claim form, unless additional time is needed. The time for response may be extended for up to an additional 15 days if necessary, due to matters beyond the control of the appropriate claims-processing entity. You will receive written notification of such extension before the end of the initial 15-day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which a decision is expected to be made.

If you improperly file a Pre-Service Claim, you will be notified within 5 days after receipt of the claim of the proper procedures to re-file the claim. If the claim is not properly re-filed, it will not constitute a claim. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given 45 days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, your claim will be decided based on the information available. During this 45-day period, the deadline for making a decision on your claim will be suspended from the date of the extension notice for either 45 days or until the date on which your response is received, whichever is earlier. The appropriate claims-processing entity will then have 15 days to make a decision on your Pre-Service Claim and notify you of its determination.

Urgent Care Claims

An Urgent Care Claim is a Pre-Service Claim that requires shortened time periods for making a determination because the longer time periods for making non-Urgent Care determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a Doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care of treatment that is the subject of the claim.

If your Urgent Care Claim is filed improperly, you will be notified of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. You will be notified of the decision on your Urgent Care Claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the Plan.

If more information is needed to decide your Urgent Care Claim, you will be notified of the specific information necessary to complete the claim within 24 hours after receipt of the claim by the appropriate claims-processing entity. You will then have up to 48 hours to provide the requested information. You will be notified of the decision within 48 hours after the earlier of:

- The Fund's receipt of the specified information, or if earlier,
- The end of the period you were given to provide the specified information.

Concurrent Care Claims

A Concurrent Care Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. An example of a Concurrent Care Claim is an inpatient Hospital stay that was initially certified for five days and is reviewed at three day intervals to determine if additional days are appropriate. In this case, the decision to reduce, end or extend treatment is being made while treatment is taking place.

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care Claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care Claims (see above), except that you will be notified of the decision (whether approved or denied) within 24 hours after receipt of the claim, provided that the claim is properly filed at least twenty-four 24 hours before the end of the previously approved period of time or number of treatments.

Post-Service Claims

A Post-Service Claim is any claim submitted for payment after health services and treatment have already been obtained. If your Post-Service Claim is denied, in whole or in part, you will be notified of the claim denial within 30 days after the claim is received. The period for a decision may be extended for up to 15 additional days due to matters beyond the control of the appropriate claims-processing entity, provided that you receive advance written notice of such extension before the end of the initial 30-day period expires. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which a decision is expected to be made.

If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given 45 days from receipt of the notice to provide the requested information. If you do not provide the information requested, your claim will be decided based on the information available. During this 45-day period, the deadline for making a decision on your claim will be suspended for either 45 days or until the date on which your response is received, whichever is earlier.

HRA/WRA Claims

If you wish to receive a reimbursement from your HRA or WRA, you must provide the Fund Office with a claim form. For reimbursements from the HRA, you must also include appropriate supporting documentation as described in Appendix A, as amended. You will receive a decision

within 30 days of the date your claim is received by the Fund. This period may be extended by an additional 15 days if an extension is necessary. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a determination is expected to be made.

If an extension is needed because additional information is required from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided, your claim will be decided based on the information provided.

Claims Denial Notification

You will be provided with a written notice of any denial of a claim (whether denied in whole or in part), which will include the following information:

- The claim involved (including the date of service, the provider involved, if applicable, and the claim amount);
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- if the denial of your claim was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
- 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 (including voluntary appeals, if any) and external review process and applicable time limits;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- for Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims (keep in mind that for Urgent Care Claims, you may first be notified over the phone or in person, with written notification to follow).

As part of the Fund's internal claims and appeals review process, you have the right to review your claim file and to present evidence and testimony in support of your claim and appeal. You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the Fund, the Board of Trustees, or the Fund's other applicable claims-processing entities.

Appealing a Denied Claim

For life insurance, which is an insured benefit, refer to your insurance booklet for information as to how to file a claim or appeal.

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. Your request for review must be made in writing to Excellus BlueCross BlueShield at Customer Advocate Unit, PO Box 4717, Syracuse New York 13221 within 180 days after you receive notice of denial. Appeals involving Urgent Care Claims may be made orally by calling Excellus BlueCross BlueShield at 1-877-253-4797 or by fax at 315-671-6656. If your first level appeal is denied by Excellus BlueCross BlueShield, 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.

In support of your appeal, you have the right to:

- Present evidence and written testimony relating to your claim, including written comments, documents, records, and other information relating to your claim for benefits;

- Upon request, obtain reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits; and

- Review your claim file.

In making a decision on review, the reviewer will review and consider all comments, documents, records, and other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered during the initial claim determination. In reviewing your claim, the reviewer will not automatically presume that the initial decision was correct, but will independently review your appeal. If any new or additional evidence is considered in connection with your appeal, that evidence will be provided to you, free of charge, as soon as possible, and you will be given an opportunity to respond. Further, if the decision is based on a new or additional rationale, you will receive an explanation of the rationale, and you will be given an opportunity to respond before a final determination is made on your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate), the reviewer will consult with a health care professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice on the initial claim.

In the case of an appeal of an Urgent Care Claim, the reviewer will notify you of the decision on your appeal within 72 hours after receipt of your appeal. In the case of an appeal of a Pre-Service Claim or a Concurrent Care Claim, Excellus BlueCross BlueShield will notify you of the decision regarding your first-level appeal within 15 days after receipt of your appeal. If you file a second level appeal to the Fund's Board of Trustees, or a committee of the Board of Trustees, you will be notified of the decision within 15 days of the date on which your appeal is received by the Fund. You may also be asked to voluntarily extend the period of time for the reviewer to make a decision on either level of your appeal.

For Post-service Claims, first-level appeals will be heard by Excellus BlueCross BlueShield within 30 days after receipt of your appeal. If you are unsatisfied with the decision of Excellus BlueCross BlueShield and decide to file a voluntary second-level appeal to the Fund's Board of Trustees, the Board of Trustees will hear your appeal at its next regularly scheduled meeting that is at least 30 days after your appeal is received by the Fund. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing of the circumstances requiring the extension and the date on which a decision is expected. In no event will a decision be made later than the third meeting after receipt of your appeal. The Trustees will send you 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. Please remember that you are not required to appeal a decision regarding your claim. However, you must exhaust your administrative remedies before you have the right to seek external review or file suit in federal court. You have a right to file suit in federal or state court under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") on your claim for benefits. Failure to exhaust these administrative remedies will result in the loss of your right to file suit.

For Prescription Drug Claims:

If your appeal for prescription drug benefits is denied in whole or in part, you have 180 days to appeal that denial to Express Scripts. If your appeal is denied by Express Scripts, you may file a second appeal with Express Scripts within 60 days after the date on which your first appeal is denied. You are not required to file a second appeal, however, unlike with respect to medical/hospital claims, you must do so in order to be eligible to file a lawsuit regarding your prescription drug benefits under ERISA.

With respect to prescription drug claims decided by Express Scripts, a decision will be made regarding your appeal within 30 days of the date on which Express Scripts receives your first level appeal and within 30 days of the date on which Express Scripts receives your second level appeal.

Notification of Appeal Denial

If your appeal is denied, you will be notified of the following:

- The claim involved (including the date of service, the provider, if applicable, and the claim amount);
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered a request for external review);
- The specific reason or reasons for denial, including the standards used and a discussion of the decision;
- Reference to specific Plan provisions on which the denial is based;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- If the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement of your right to seek external review and to bring a civil action under Section 502(a) of ERISA following a denial of your appeal. If you wish to file suit for a denial of a claim of benefits, you must do so within two years of the later of the date on which (i) the Trustees denied your appeal or (ii) the IRO rendered a decision against you on external review. For all other actions, you must file suit within two years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the Trustees, you must file suit in one of the United States District Courts in the State of New York. These rules apply to you and your spouse or other dependents.

External Review of Denied Claims

If your claim for self-insured benefits has been denied and if you have exhausted the Fund's internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an external independent review organization (IRO). External review is limited to claims involving medical judgment (e.g., lack of Medical Necessity, or a determination that a claim is Experimental or cosmetic) or a rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed within four months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal). Requests for external review are generally filed with the Fund office except that requests involving prescription drug claims must be filed directly with Express Scripts.

Preliminary Review. Within five business days of receiving your request for an external review, the Fund, or ESI, as applicable, will complete a preliminary review of your request to determine whether it is eligible for external review (e.g., whether you have exhausted the Fund's claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review, except to the extent required by law, that the preliminary review may be referred to an IRO to determine whether the claim involves medical judgment. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) it is not eligible, and you will receive contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original four-month filing period or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever is later.

Referral to Independent Review Organization ("IRO"). If your external review request is complete and your claim is eligible for external review, your claim will be forwarded to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review.

You are permitted to submit in writing to the assigned IRO, within ten business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to the Fund, or ESI, as applicable. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund, or ESI, as applicable, decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

In making its decision, the IRO will review all of the information and documents it timely receives, and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its decision within 45 days after it receives the request for review. The IRO's decision notice will contain:

- A general description of the claim and the reason for the external review request;
- The date the IRO received the external review assignment and the date of its decision;
- Reference to the evidence considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to you; and
- Contact information for any applicable consumer assistance office.

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

Reversal of the Fund's decision. If the IRO issues a final decision that reverses the Fund's decision, the Fund will pay the claim.

Expedited External Review of Denied Claims

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant has not yet been discharged from the facility. You may request an expedited external review at the same time an appeal is submitted to the Fund's Board of Trustees.

Immediately upon receiving your request for expedited external review, a determination will be made as to whether your request is eligible for external review as described above. The Fund will immediately send you a notice of its eligibility determination.

If your claim is determined to be subject to external review, the IRO will provide a decision on as soon as possible under the circumstances but no more than 72 hours after receiving the expedited request for review.

Lawsuits

If you wish to file suit for a denial of a claim of self-insured benefits, you must do so within two years of the later of the date on which (i) the Trustees denied your appeal or (ii) the IRO rendered a decision against you on external review. For all other actions, you must file suit within two years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the Trustees, you must file suit in one of the United States District Courts in the State of New York. These rules apply to you and your spouse or other dependents.

Privacy of Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

These provisions will remain in effect unless and until the Fund provides you with a revised Notice of Privacy Practices.

The Fund is committed to protecting the privacy of your protected health information Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. This Section constitutes the Fund's Notice of Privacy Practices. In accordance with applicable law, you have certain rights under the privacy rules of Health Insurance Portability and Accountability Act of 1996 ("HIPAA") the related regulations ("federal health privacy law"), as described in this Section, related to your health information. Specifically, you have the right to:

- maintain the privacy of your health information;
- receive this notice describing the Fund's legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this provision.

INFORMATION SUBJECT TO THIS SECTION

The Fund collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Fund obtains this health information from forms that you complete, through conversations you may have with the Fund's administrative staff and health care professionals, and from reports and data provided to

the Fund by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Section. The health information the Fund has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information.

SUMMARY OF THE FUND'S PRIVACY PRACTICES

The Fund's Uses and Disclosures of Your Health Information. The Fund uses your health information to determine your eligibility for benefits, to process and pay your insured health benefits claims, including HRA reimbursements, and to administer its operations. The Fund discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Fund may also disclose your health information to third parties that assist the Fund in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Fund will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Fund's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information. The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- Request access to your health information in an electronic format;
- File a complaint with the Fund office or the Secretary of the U.S. Department of Health and Human Services if you believe that your that privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below. The Fund reserves its right to change its privacy practices as described below.

Contact Information. If you have any questions or concerns about the Fund's privacy practices, or about this Notice, or if you wish to obtain additional information about the Fund's privacy practices, please contact:

HIPAA Privacy Officer
Northeast Carpenters Health Fund
91 Fieldcrest Avenue
Edison, New Jersey 08818
(732) 417-3900

Except as described in this section, as provided for by federal privacy law, or as you have

otherwise authorized, the Fund uses and discloses your health information only for the administration of the Fund and the processing of your health claims.

DETAILED NOTICE OF THE FUND'S PRIVACY POLICIES

Uses and Disclosures for Treatment, Payment, and Health Care Operations.

- **For Treatment.** Although the Fund does not anticipate making disclosures "for treatment," if necessary, the Fund may make such disclosures without your authorization. For example, the Fund may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.

- **For Payment.** The Fund may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Fund's program of benefits. For example, the Fund may share your enrollment, eligibility, and claims information with the Fund's claim processors, so that they may process your claims. The Fund may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered. The Fund also may disclose your health information to insurers or other benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, the Fund may disclose your health information to claims auditors to review billing practices of health care providers and to verify the appropriateness of claims payment.

- **For Health Care Operations**. The Fund may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Fund may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Fund.

Uses and Disclosures to Business Associates. The Fund shares health information about you with its "business associates," which are third parties that assist the Fund in its operations. The Fund discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Fund shares your health information with the Fund's claim processors so that they may process your claims. The Fund may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Fund may disclose your health information to a translator; and the Fund may provide names and address information to mailing services.

The Fund enters into agreements with its business associates to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor. The Fund may disclose your health information to the Fund's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Fund, without your authorization. The Fund also may disclose your health information to the Trustees for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Trustees, the Trustees will certify to the Fund that it will protect your health information and that included

language in this document to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization. As described below, the federal health privacy law provides for specific uses or disclosures that the Fund may make without your authorization.

- **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:
    - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
    - To report information related to victims of abuse, neglect, or domestic violence.
    - To assist law enforcement officials in their law enforcement duties.
- **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.
- **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.
- **Active Members of the Military and Veterans**. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
- **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.
- **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.
- **Others Involved In Your Care**. Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Fund has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Fund). Also, upon request, the Fund may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this

information to be shared, you may request that these disclosures be restricted as below.

- **Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

- **Treatment and Health-Related Benefits Information**. The Fund and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.

- **Research**. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

- **Organ, Eye and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

- **Deceased Individuals**. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes. The Fund and its business associates do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization. Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Fund will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Fund already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Fund creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Northeast Carpenters Health Fund
91 Fieldcrest Avenue
Edison, New Jersey 08818
(732) 417-3900

Right to Inspect and Copy Health Information. You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your Fund eligibility, plan coverage, claim records, and billing records. For health records that the Fund keeps in electronic form, you may request to receive the records in an electronic format. To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Fund will send you a claims report that is a summary of your claims history that covers the previous six years. If you have been eligible for benefits for less than six years, then the report will cover the entire period of your coverage.

If you do not agree to receive a claims history report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a six-year period, state that in your written request, and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the Fund will charge you a fee of $.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format may also be subject to a small charge to reflect the Fund's labor costs in providing you the records.

In certain limited circumstances, the Fund may deny your request to inspect and copy your health record. If the Fund does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request That Your Health Information Be Amended. You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Fund may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Fund, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Fund;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Fund will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Fund denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures. You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Fund to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The

accounting covers up to six years prior to the date of your request. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Fund may provide you with a list of business associates who make such disclosures on behalf of the Fund, along with contact information so that you may request the accounting directly from each business associate. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but the Fund will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions. You have the right to request restrictions on your health care information that the Fund uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that the Fund discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. Except in the case of disclosures for payment purposes where you have paid the health care provider in full out of pocket, the Fund is not required to agree to your request for such restrictions, and the Fund may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Fund will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location. You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain. You have the right to complain to the Fund and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Fund, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Fund or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above.

Right to Receive Notice of a Breach of Your Protected Health Information. We are required to notify you if your unsecured protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of unsecured protected health information. The notification requirements under this section apply only if the breach poses a significant risk for financial, reputational, or other harm to you. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every disclosure of health information is a breach that requires notification: you may not be notified if the health information that was disclosed was adequately secured—for example, computer data that is encrypted and inaccessible without a password—or if the Fund determines that the disclosure does not pose a significant risk of harm to you.

CHANGES IN THE FUND'S PRIVACY POLICIES

The Fund reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Fund materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision.

BOARD OF TRUSTEES OBLIGATIONS WITH RESPECT TO PROTECTED HEALTH INFORMATION

In order to permit the Fund's Board of Trustees to carry out its administrative duties with respect to the Fund, the Board of Trustees may, consistent with the federal privacy rules, receive protected health information ("PHI") from the Fund or the Fund's health insurer and other providers, subject to the following restrictions:

- The Board of Trustees may use and disclose PHI as necessary to administer the benefits described in this booklet, to the extent consistent with law and the Fund's governing documents. Except as permitted by Business Associate Agreements (as described above), no individuals will be given access to PHI intended to be disclosed to the Trustees.

- The Board of Trustees may only receive PHI from the Fund or the Fund's health insurer after the Trustees have advised, in writing, of their adoption of these rules governing the use and disclosure of PHI as required by applicable law. In addition, the Board of Trustees will:

    - not use or further disclose PHI other than as permitted or required by the Fund's governing documents or as required by law;

- ensure that any agents, including subcontractors, to whom the Trustees provide PHI that is received from the Fund or health insurer, agree to the same restrictions and conditions that apply to the Trustees with respect to such information;

- not use or disclose the information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees;

- report to the Fund or, if applicable, the Fund's health insurer, any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures of which the Board of Trustees becomes aware;

- make PHI available to Participants in accordance with applicable law;

- make PHI available to Participants for amendment, and incorporate any amendments to PHI, in accordance with applicable law;

- make available to Participants the information required to provide an accounting of disclosures in accordance with applicable law;

- make the Board of Trustees' internal practices, books, and records relating to the use and disclosure of PHI received from the Fund or, if applicable, from the Fund's health insurer, available to the Secretary of Health & Human Services upon request for purposes of determining compliance by the Fund;

- to the extent possible, return or destroy all PHI received from the Fund or health insurer, that the Board of Trustees maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that adequate separation between the Fund and the Board of Trustees exists to assure the confidentiality of the PHI, as required by applicable law.

- In addition, the Board of Trustees will:

  - implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;

  - ensure that the adequate separation between the Board of Trustees and the Fund is supported by reasonable and appropriate security measures

  - ensure that its agents and Business Associates to whom it provides electronic PHI agree to implement reasonable and appropriate security measures; and

- report to the Fund any security incident of which the Board of Trustees becomes aware.

Other Information You Should Know

Financing the Plan

Contributions to the Fund are made primarily by Employers that have entered into collective bargaining agreements with the Union or participation agreements with the Fund, requiring that contributions be made to the Fund.

How Benefits May Be Forfeited or Delayed

There are certain situations under which self-insured benefits may be forfeited or delayed, such as if you:

- do not timely submit a claim for self-insured benefits;
- do not provide the information required to complete or verify a claim for an self-insured; or
- do not have a current address on file with the Fund Office.

Plan benefits are not payable for any enrolled Dependents who is ineligible due to age, divorce or legal separation unless such Dependent elects to continue coverage under COBRA, as described in pages 20-23.

No Liability for the Practice of Medicine

Neither the Fund, nor the Board of Trustees or any of its designees:

- are engaged in the practice of medicine nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider; and

- will have any liability whatsoever for any loss or injury caused by any health care provider by reason of negligence failure to provider care or treatment, or otherwise.

Compliance with Law

The Fund is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor and current tax and ERISA laws. The provisions in this booklet will always be construed to comply with these regulations, rulings and laws.

Plan Amendment or Termination

The Board of Trustees intends to continue the Plan indefinitely, but reserves the right to amend or terminate it in its sole discretion. Please remember that benefits provided under this Plan are not vested. Therefore, at any time, the Board can end or amend benefits, including but not limited to, retiree benefits, in its sole and absolute discretion. At any time, the Fund can change

insurance companies or modify its contracts with Excellus and/or Dearborn.

Coordination of Benefits With Medicare and Other Programs

Active Employees Age 65 and Over and Their Dependents

Generally, the Fund's self-insured benefits, including HRAs, will be primary for participants working in Covered Employment over the age of 65 and their spouse. However, if you are receiving self-insured benefits from the Fund under COBRA, Medicare will be primary, to the extent permitted by applicable law. Also, an active employee or spouse may decline coverage under the Plan and elect Medicare as primary. In that instance, the Fund will not pay benefits secondary to Medicare for Medicare covered services. In the event Medicare seeks reimbursement from the Fund for amounts for which the Fund should have paid primary from your HRA, but did not, such amounts will be deducted from your HRA. In the event your HRA has an insufficient balance, the individuals to whom the claims apply shall be responsible for reimbursement to Medicare, not the Fund.

Disabled Employees or Disabled Dependents Under 65

If you or your Dependents become eligible for Medicare due to disability while you are actively working in Covered Employment, this Plan will provide your primary coverage and Medicare will be secondary for as long as you continue to work in Covered Employment. If you are not working in Covered Employment, and you or your Dependents become eligible for Medicare due to disability, Medicare is primary and this Plan is secondary for each covered family member eligible for Medicare. Any covered family members not eligible for Medicare will receive primary coverage under this Plan.

End Stage Renal Disease

For Participants and Dependents with end-stage renal disease, Medicare is the secondary payer during the first 30 months of treatment. After this 30-month period is over, Medicare permanently becomes the primary payer. This is true even if Medicare would be secondary for some other reason. This Plan will pay secondary after the first 30-month period even if you fail to enroll in Medicare coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan is primary and Medicaid pays secondary.

Retirees

If you retire and become eligible for Medicare while covered under this Plan, Medicare will be primary and this Plan will be secondary to Medicare. Please note that if you or your Dependents are eligible for Medicare but choose not to enroll in Medicare coverage, this Plan will apply the Coordination of Benefits rules as though your Dependents are enrolled in Medicare. Therefore, you and your Dependents are encouraged to enroll in Medicare when they become eligible.

TRI-CARE. If you or your Dependents are covered under TRI-CARE, this Plan pays primary and TRI-CARE pays secondary.

No-fault benefits. If a person covered by this Plan has a claim which involves a motor vehicle accident covered by the "No-Fault" insurance law of any state, health care expenses must be reimbursed first by the "No-Fault" insurance carrier. Only when the claimant has exhausted his health care benefits under the "No-Fault" coverage may such individual be entitled to receive health care coverage under this Plan. If there are expenses for services which are covered under this Plan and which are not completely reimbursed by the "No-Fault" carrier, this Plan will consider for reimbursement claims for the difference, subject to the Plan's applicable maximums and other provisions.

Workers Compensation. This Plan does not cover benefits for expenses covered by Workers Compensation or occupational disease laws. If an employer disputes the application of Workers Compensation laws for an illness or injury, the Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under Workers Compensation or occupational disease law.

Other Health Coverage

If you have coverage through a private health plan (e.g., through your spouse's employer's), the Fund will coordinate your benefits with that other plan. The rules for determining which plan is the primary payer and which plan is the secondary payer are described in the booklet prepared by Excellus.

Plan Facts

Plan Name	Northeast Carpenters Health Fund
Edition Date	This Summary Plan Description includes the rules of the Plan as of July 1, 2017.
Plan Sponsor and Plan Administrator	Board of Trustees Northeast Carpenters Health Fund 91 Fieldcrest Avenue Edison, New Jersey 08818 (732) 417-3900
Employer Identification Number	22-6032181
Plan Number	501
Type of Administration and Funding of Benefits	The Plan is a group health plan. The Fund's life insurance coverage is fully insured by Dearborn. All other benefits provided under this Plan are self-insured.
Plan Year End	The Fund's Plan Year ends December 31st
Agent for Service of Legal Process	Peter Tonia, Fund Director Northeast Carpenters Health Fund 91 Fieldcrest Avenue New Jersey 08818 (732) 417-3900 In addition, service of process can be made on the Trustees individually. With respect to the insured life insurance benefits, please refer to the Dearborn booklet to determine the proper agents for service of process.
Sources of Plan Contributions	Contributions are generally made by Employers pursuant to the terms of a collective bargaining agreement with the Union or a participation agreement with the Board of Trustees.
Collective Bargaining Agreements	The Fund is maintained in accordance with collective bargaining agreements. You may examine any collective bargaining agreement maintaining the Plan at the Fund office during normal business hours. In addition, you may request a copy of a collective bargaining agreement to be sent you by sending a written request to the Fund Office.
Participating Employers	Upon receipt of a written request, the Fund Office with provide you with information as to whether a particular employer contributes to the Plan. Additionally, a complete list of all Contributing Employers and Unions sponsoring the Plan can be obtained upon written request to the Fund office.
Contact Information	
Medical, Dental and Vision	Excellus BlueCross Blue Shield Website – www.excellusbcbs.com Medical and Vision Customer Service 1-877-757-3850 Dental Customer Service 1-800-724-1675
Prescription Drugs	Express Scripts P.O. Box 14711 Lexington, KY 40512 Express Scripts Customer Service 1-800-949-9036 Accredo Specialty Pharmacy Customer Service 1-800-803-2523
Life Insurance	Dearborn National Life Insurance Co. 1020 31st Street Downers Grove, IL 60515

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions, financial or otherwise, so warrant.

Your Rights Under ERISA

As a participant in the Northeast Carpenters Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. You should review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health benefit or exercising your rights under ERISA.

Enforce your Rights

If your claim for a health benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Office. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order

the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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.	• For premiums for the Fund's medical 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. • 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: • Date of service • Patient name • Description of services rendered (procedure code and diagnosis code if available) • Cost of services rendered • Name and address of provider.
Medical Premiums • Post-tax medical, dental or vision premiums that are paid to a qualified individual or group health plan. • Medicare • COBRA premiums that are paid to a qualified individual or 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 insurance through a State Health Plan marketplace	• For premiums for the Fund's medical 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. • 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 individual or 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	• 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

• 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.	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 or Contact lenses • 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	• Explanation of Benefits (EOB) or Health Statement • If payment is being made to the covered person,

aids • Batteries needed to operate the hearing aid • Hearing exams **If you are not eligible for hearing aid coverage because of age, you can still 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.**	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
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 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.

* 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)
- Stop-Smoking Program
- Tanning Bed
- Missed Appointment Fees, Late payment fees or Cancellation fees
- Shipping Fees
- Extended Warranties for Durable Medical Equipment
- New York State medical surcharges
- Marijuana
- Vitamins (except as noted above)