New England Carpenters
Health Benefits Fund

HEALTH BENEFITS | FUND

SUMMARY PLAN DESCRIPTION | GREAT BENEFITS FOR LIFE

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Orginal Date: October 2016
Updated: January 1, 2020

BOARD OF TRUSTEES

New England Carpenters
Health Benefits Fund

350 Fordham Road
Wilmington, MA 01887
PH: 800-344-1515
FAX: 978-752-1148

October 2016

Dear Participant:

Your good health and well-being are important to the New England Carpenters Health Benefits Fund Board of Trustees. That's why the Trustees are pleased to issue this revised Summary Plan Description describing the comprehensive benefits package offered to eligible participants and their dependents. We are pleased that effective October 2016, with the merger of the Western Mass Local 108 Plan, all participants will have access to the Plan of Benefits described here, with Blue Cross Blue Shield of Massachusetts as the claims administrator and PPO network provider.

The Plan described in this document is effective August 1, 2016, except for those provisions that specifically indicate other effective dates, and replaces all other plan document/summary plan descriptions previously provided to you. This book provides the required information about your rights and protection under the law in order to comply with the Employee Retirement Income Security Act of 1974 (ERISA).

However, we all share a responsibility in the health of the Plan. As your Board of Trustees, our goal is to offer a comprehensive plan of benefits for you and your family, while maintaining a financially sound Health Benefits Fund. For your part, taking advantage of the benefits and services the Fund offers—especially preventive care designed to identify chronic conditions early—is all a part of keeping you, and the Fund, in good health.

We encourage you and your family to read this Summary Plan Description carefully to make the best use of the benefits the New England Carpenters Health Benefits Fund offers. If you have any questions concerning the benefits or your eligibility, please feel free to contact the Fund Office at 800-344-1515.

Sincerely,

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LEGAL COUNSEL

O'Reilly, Grosso, Gross & Jones
Krakow, Souris & Landry, LLC

CONSULTANTS AND ACTUARIES

Segal Consulting

The Board of Trustees reserves the right to terminate or amend the Plan at any time. This includes the right to amend or terminate benefits or eligibility for any class of participant, including retirees, when in their sole discretion the Board determines such action is in the best interest of the Fund and its participants.

Changes to your plan of benefits can happen at any time, so if you have a question about a particular service or program, contact the Fund Office for the most up-to-date information.

Welcome to the **Health Benefits Fund**

This book has been designed to be easy to read and understand. Benefit highlights appear at the beginning of each section to give you a quick overview of what is contained within that section.

Certain terms used in this document have specific meanings within the context of the Plan and are defined in the Glossary on page 93.

HOW THE HEALTH BENEFITS FUND WORKS

The benefits described in this book pertain to participants who meet the Fund's eligibility requirements described on page 47, and their dependents.

The Health Benefits Fund contains three comprehensive health care plans, which offer coverage depending on your eligibility:

- **Plan I and Plan II, for active participants and their dependents; and**
- **The Retiree Health Benefits Plan, for eligible retirees and their dependents.**

The Schedule of Benefits for each of the three plans, beginning on page 97, shows how coverage is different under each Plan.

Certain services are not covered, as described in the General Exclusions, or are partially covered, as detailed in the Schedule of Benefits.

Participating employers contribute to the Fund (in accordance with Collective Bargaining Agreements entered into by the employers and the local unions that act on behalf of participants) to provide Plan benefits. Your employer contributes to the Fund based on your hours worked. Your eligibility for the Plan is also determined by your hours worked with your employer (called "covered employment") and further described in this booklet. The Plan is administered by a Board of Trustees, which is composed of an equal number of employer and union representatives (see listing on the inside cover). The Trustees are charged with applying and interpreting the rules and regulations of the Plan.

WHO TO CONTACT ABOUT YOUR BENEFITS

BENEFIT	PROVIDER	PHONE NUMBER	WEBSITE
Eligibility, Enrollment, COBRA, etc.	The New England Carpenters Health Benefits Fund	Phone: 800-344-1515 Fax: 978-752-1148	www.carpentersfund.org
Medical	Blue Cross Blue Shield of Massachusetts (BCBSMA)	800-810-2583 to find PPO provider or free-standing CT scan or MRI facility	www.bluecrossma.com
	BCBSMA Prior Authorization	800-327-6716	
	BlueCare Nurse Line	888-247-BLUE (2583)	
	Minute Clinic	Call local CVS to see if they offer a Minute Clinic	www.cvs.com
Prescription Drugs	Express Scripts	800-939-3750	www.express-scripts.com
	Diplomat Specialty Pharmacy	888-514-5156 For prior authorization: 888-515-1357	
Dental	Delta Dental PPO Plus Premier Group Number 007525-9001	800-872-0500 to find a dentist	www.deltadentalma.com
Vision	Carpenters Vision Center located at Carpenters Care 750 Dorchester Avenue Boston, MA 02125	617-782-0100 if you have questions or to make an appointment	
	Davis Vision	800-999-5431	www.davisvision.com
Carpenters Assistance Program	Employee Assistance Program through KGA	800-648-9557	http://links.kgreer.com/carpenters
	Carpenters Assistance Program for Substance Abuse and Addiction through Paul Greeley	800-344-1515, extension 1160	
Hearing Aids	HearUSA to get information about hearing aids	800-700-3277	www.hearusa.com
Help with Quitting Smoking	The Massachusetts Smoker's Hotline	800-QUIT-NOW	Check out other programs available on the Quitworks website at http://quitworks.makesmokinghistory.org

MEDICAL PLAN
& WELLNESS BENEFITS

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

Your Medical Plan & Wellness Benefits

The New England Carpenters Health Benefits Fund provides a comprehensive medical plan offering a broad range of medical services designed to keep you in good health. Medical benefits are provided through the Blue Cross Blue Shield of Massachusetts (BCBSMA) network of participating providers and facilities.

WELLNESS BENEFITS AND PROGRAMS

Having good health is the key to a happy life. The Fund strives to help our participants achieve and maintain good health through the wellness programs we offer, below, and described under the Carpenters Care tab.

- Preventive Care Benefits (covered at 100% In-Network). For a list of covered services, see page 16.
- A Preferred Provider Organization (PPO) network of doctors and hospitals through Blue Cross Blue Shield of Massachusetts (BCBSMA).
- Blue Care 24-hour Nurse Line is a telephone service provided by BCBSMA that allows participants to speak with a registered nurse, discuss symptoms and ask medical questions 24 hours a day, 7 days a week, at no cost to you.

BCBSMA nurses will help you assess whether you need to see a doctor, go to the emergency room or treat yourself at home. These nurses are supported by physicians and use evaluation tools to provide you with valuable health information. Call Blue Care Line at 888-247-BLUE (2583).

CARPENTERS CARE

- The Carpenters Vision Center, with a special focus on vision needs of Carpenters and their families; and
- The Carpenters Assistance Program for substance abuse disorder, and help with personal and family issues through our partner, KGA. See the tab on Carpenters Care for more details on these programs.

Tobacco Cessation and Prevention Program

The Fund provides support to help you quit tobacco through free nicotine patches and counseling calls. Simply call 800-Try-to-Stop and identify yourself as a New England Carpenter (or a dependent age 18 or older) to hear about the resources available to help you kick the habit. This benefit includes:

- Initial screening to determine your smoking status;
- Screening for nicotine patch eligibility;
- Telephone counseling;
- Nicotine Replacement Therapy, (e.g., patches, lozenges or gum) is offered through the Massachusetts Department of Public Health's program (and supplemented by the New England Carpenters Health Benefits Fund) to help state residents quit smoking. Call 800-QUIT-NOW for information

10 THINGS YOU CAN DO TO STAY HEALTHY AND MANAGE YOUR HEALTH CARE COSTS

1. **Establish a relationship with a network primary care physician.** Visit www.bluecrossma.com or call 800-810-2583 to find network providers. Or consider receiving your primary care from Iora, located at Carpenters Care, for convenient access to a personal physician team, available 24/7 with guaranteed same-day or next-day appointments if you're sick.

2. **Call the Blue Care Nurse Line** at 888-247-BLUE (2583) if you're wondering if you have a true medical emergency or have any health question. Instead of the ER, consider using an urgent care clinic to receive quick preventive care or care for minor illness/injury.

3. **Choose a free-standing facility when possible if you need to get an MRI or CT scans** (not part of a hospital). You'll pay less out of your pocket, and save the Fund.

4. **Ask for generics and use the mail-order program,** and you'll pay less.

5. **Fill your prescriptions and take your medications as prescribed—**follow doctor's orders! If you have troublesome side effects, call your doctor to discuss. He or she can prescribe another medication to try. You should consult your doctor before you stop taking prescribed medications.

6. **Review Explanation of Benefits statements** that you receive from the Fund Office after a doctor's visit or hospital stay to ensure that the services, dates and charges listed are correct.

7. **Keep yourself healthy—**eat right, get enough sleep, move at least 30 minutes a day and get your annual preventive care medical check-up and recommended screenings and immunizations.

8. **Don't forget to schedule and keep regular dental checkups (Plan I only) and Carpenters Vision Center visits!**

9. **The Carpenters Vision Center** in Dorchester offers complete eye exams and the largest selection of frames available under the Plan. You'll also receive discounts for services that aren't covered under the other vision plans available as part of your Health Benefits Fund coverage.

10. **The Carpenters Assistance Program (CAP) is available to help with personal issues.** Contact KGA, our CAP partner, toll-free at 800-648-9557 to speak confidentially with a counselor or to make an appointment.

How Your Medical Plan Works

PLAN YEAR

The Plan is administered on a calendar-year basis (January 1 – December 31) so all references to a Plan Year mean a calendar year.

LIFETIME MAXIMUM BENEFITS

There is no overall lifetime maximum benefits paid by the Plan. However, there are benefit limits, as explained below.

BENEFIT LIMITS

Note that limits apply on certain benefits. These limits are spelled out in the charts found in this Summary Plan Description.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund contracts with BCBSMA (Blue Cross Blue Shield of Massachusetts) for access to its network of doctors, hospitals and other health care providers, or PPO. Visit www.bluecrossma.com/findadoctor or call 800-810-2583 for a list of preferred medical providers, free of charge.

In-network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by a BCBSMA network provider. The network provider will assess your medical needs and advise you on appropriate care, as well as take care of any necessary tests, prior authorizations or inpatient hospital admissions.

You may visit any provider you wish, however, your out-of-pocket costs will be lower if you use a provider who participates in the Plan's Preferred Provider Organization (PPO) network, through BCBSMA. For a summary of the benefits offered, refer to the Schedule of Benefits on pages 97-103.

ALLOWED AMOUNT

The allowed amount or allowable charge is the charge that in-network providers are allowed to bill you based on their contract with Blue Cross Blue Shield. When you use PPO network providers, you pay less because your share of the cost is based on a pre-negotiated, reduced charge. If you go out-of-network, you are responsible for paying any amount the provider charges above the allowed amount.

The allowed amount, meaning the amount the Plan will pay, for out of network services will be the in-area in-network allowed amount or, if out of state, the local Blue Cross Blue Shield allowed amount,whichever is lower. This means that, if you use an out-of-network provider, the "allowed amount" will be based on the amount that an in-network provider accepts as payment in full. The out-of-network provider can bill the patient the difference between the allowed amount and the billed amount.

THE ANNUAL DEDUCTIBLE

The annual deductible is an annual dollar amount you (and/or your family) must pay in medical expenses before the Fund will begin to pay its share of the cost each year. Please refer to the Schedule of Benefits to determine which medical services require you to meet an annual deductible before the Plan pays benefits.

OUTPATIENT SERVICES

The annual deductible and coinsurance applies to outpatient services. Please refer to the Schedule of Benefits. **Many services previously covered at 100% will now be subject to deductible and coinsurance.**

The annual deductible is the same for in-network and out-of-network care. This means that in-network and out-of-network expenses both accumulate toward the one annual deductible. (Refer to your plan's summary chart for details.) Generally, the deductible does not apply to preventive care services.

How does the family deductible work?

The family annual deductible is met once one family member meets his/her individual deductible amount and all other family members combined meet a second individual deductible amount.

MAXIMUM LIMIT ON ANNUAL OUT-OF-POCKET EXPENSES

The Fund has a separate annual out-of-pocket maximum for medical expenses and for prescription drug expenses.

The annual out-of-pocket maximum is a limit on the amount each participant or family has to pay out of pocket for covered expenses in a given Plan Year. Once your share of expenses in a given year reaches the annual out-of-pocket maximum, the Plan will pay 100% of the allowed amount for any additional covered expenses you incur for the rest of the year.

The limits for out-of-pocket expenses for medical and prescription drug benefits are shown in the chart below.

	MEDICAL ANNUAL OUT-OF- POCKET MAXIMUM	PRESCRIPTION DRUG ANNUAL OUT-OF-POCKET MAXIMUM*	TOTAL ANNUAL OUT-OF-POCKET MAXIMUM (FOR BOTH)
Plan I			
Member	$2,000	$3,600	$5,600
Family	$4,000	$7,200	$11,200
Plan II			
Member	$3,200	$3,600	$6,800
Family	$6,400	$7,200	$13,600
Retiree Health Benefits Plan			
Member	$3,000	$3,600	$6,600
Family	$6,000	$7,200	$13,200

**Note: The prescription drug limit does not include the added cost-sharing amount you would pay if you select a brand name prescription when a generic drug is available and medically appropriate (as determined by your physician).*

FOR PLAN I AND PLAN II:
Carryover Annual Deductible

Any amount you pay toward the deductible for services rendered in October, November or December of any year is applied to the deductible for the following calendar year. That way, you are saved from having to meet the deductible twice in a short period of time.

Expenses NOT INCLUDED in the annual out-of-pocket expense limits are:

- Premiums;
- Balance-billed charges (which are charges that an out-of-network provider may bill you above the Plan's allowed amount for a service);
- Health care this plan does not cover;
- Charges for not following the plan's prior authorization requirements for inpatient admissions and certain outpatient procedures; and
- Charges above the maximum benefits for certain services.

OFFICE VISIT COPAYMENT

If you visit an in-network provider, there is a $15 copayment (or "copay") due the provider at the time of the visit.

EMERGENCY ROOM COPAYMENT

The copayment for an emergency room visit is $100 per visit. The copayment will be waived only if you are admitted to the hospital or admitted for observation or if you receive emergency surgery. Applicable coinsurance for inpatient stays still apply.

COINSURANCE

Coinsurance is the portion of eligible expenses that you are responsible for paying, typically after the deductible is met. Coinsurance is usually a percentage of the provider's actual charge, or the allowed amount.

Refer to the Schedule of Benefits, beginning on page 97, for specific coinsurance information for covered services.

IF YOU GO OUT OF THE NETWORK

If you go out-of-network, eligible medical expenses are paid at a lower level, which means you pay more out of your pocket. Out-of-network care is defined as care that is not provided by a BCBSMA provider. Deductibles and coinsurance apply to eligible out-of-network medical expenses.

PRIOR AUTHORIZATION

You, the hospital or your physician must contact BCBSMA at 800-327-6716 to receive prior authorization for all inpatient hospital and mental health/substance abuse admissions, home health care services or hospice care upon discharge from an inpatient stay. Maternity admissions do not require prior authorization, unless your hospital stay needs to go longer than the typical 48 hours for a vaginal delivery or 96 hours for a C-section.

WHAT SERVICES REQUIRE PRIOR AUTHORIZATION?

Contact BCBSMA at 800-327-6716 for authorization before you receive any of the following treatments or services:

- **Inpatient hospitalization (including emergency, elective admissions and mental health/substance abuse disorder inpatient admissions, including partial hospitalization and intensive outpatient treatment);**
- **Certain outpatient surgeries;**
- **Home health care services; or**
- **Home hospice care.**

MAKE SURE YOU HAVE THE FOLLOWING INFORMATION AVAILABLE WHEN YOU CALL:

- **Name and Social Security number of the patient;**
- **Name and Social Security number of the covered participant if different from the patient;**
- **Date of proposed admission;**
- **Name, address and telephone number of the attending physician; and**
- **Name, address and telephone number of the hospital.**

You will be notified in writing of the authorization. If you have not received a written authorization by the day of your admission, call BCBSMA.

PENALTY FOR NOT OBTAINING PRIOR AUTHORIZATION FOR HOSPITALIZATION

If you do not obtain prior authorization for any hospital admission your hospitalization expenses will not be covered by the Plan.

In an emergency hospital admission, you (or someone on your behalf, such as the hospital) must notify BCBSMA by telephone within 24 hours of your admission or the next business day if on a holiday or weekend. The BCBSMA telephone number is printed on your identification card that you will need to present to your doctor and/or the admissions office of the hospital.

PRIOR AUTHORIZATION REQUIREMENT FOR OUTPATIENT SURGICAL PROCEDURES

Certain outpatient procedures require you to contact BCBSMA for prior authorization, such as the following:

- EVLT (Endovenous laser therapy) for varicose veins
- Septoplasty
- Blepharoplasty
- Breast reduction
- Abdominoplasty (panniculectomy)
- Le Fort osteotomy
- UPPP (Uvulopalatopharyngoplasty)

Please note the list above is not all-inclusive. It's always better to call BCBSMA and confirm prior authorization before any outpatient procedure.

What's Covered

The New England Carpenters Health Benefits Fund provides eligible participants and their dependents with a comprehensive plan of benefits. Coverage includes office visits, hospitalization and surgery, wellness benefits and substance abuse and mental health treatment. Coverage for prescription drugs, dental care (Plan I only) and vision care is outlined in other chapters in this booklet, and in the Schedule of Benefits. For more information about what's covered under your Plan of Benefits, refer to the Schedule of Benefits on pages 97-103. Certain benefits are described in more detail below.

What's Not Covered?
A comprehensive listing of the Fund's general exclusions are listed on page 69.

PREVENTIVE CARE AND SCREENINGS AND IMMUNIZATIONS*

- **Annual physical exams for adults, well-child and well-baby exams, and recommended preventive immunizations.**
- **Annual Pap tests and routine mammogram screenings** are covered at 100% in-network.
- **Well-woman visits** are covered 100% in-network for all females with NO visit limits.
- **Prenatal/postnatal visits** are covered with no cost-sharing in-network for all females.
- **Contraceptive methods and counseling** for all FDA-approved contraceptive methods, and patient education and counseling for all women of all ages with reproductive capacity. Generic contraceptives have no cost-sharing. Cost-sharing applies to brand name contraceptives when a generic drug equivalent is available and medically appropriate..
- **Sterilization procedures for females** (e.g., tubal ligation) and patient education and counseling for all women of all ages with reproductive capacity covered in-network with no cost-sharing.
- **Breastfeeding supplies and rental of equipment** covered in-network with no cost-sharing in-network.
- **Coverage of genetic testing** as mandated by health reform.
- **Pharmacy Vaccination Program** - Participants and their covered dependents are eligible to receive vaccinations through Express Scripts contracted retail pharmacy at no cost. A list of vaccinations are available upon request.

* The wellness and preventive care services payable by this Plan are designed to comply with health reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control and Prevention (CDC).

MRI AND CT SCAN DIAGNOSTIC TESTING

Medically necessary diagnostic MRIs and CT scans performed at an in-network free-standing radiology facility or your doctor's office will be subject to deductible and coinsurance for Plan I and Plan II.

For the Retiree Health Plan will be covered at 100% at a free standing facility or with $150 copay at a hospital.To find an in-network facility near you, contact BCBSMA at 800-810-2583 or online at www.bcbsma.com. This copay will be waived if there are no in-network free-standing radiology facilities within a 30-mile radius of your home.

HOME HEALTH CARE

Home health care helps the Fund to keep down hospital expenses by providing an alternative to inpatient hospital care or reducing the length of a hospital stay. You or a family member can receive many services at home in familiar surroundings and close to family and friends—providing a sense of security during a time of illness.

- A home health care agency is a licensed organization that provides skilled nursing and other therapeutic services for participants that are recovering from an injury or illness in the comfort of their own home.
- Note that help with daily living (custodial care) is covered only if provided in your home at the direction of a hospice organization. See "Hospice Care" on page 18.

Medically necessary home health care services must be preauthorized. To be covered, your doctor must contact

HOME HEALTH CARE			
	PLAN I	PLAN II	RETIREE HEALTH BENEFITS PLAN
PPO NETWORK	80% after deductible.	70% after deductible.	100% after deductible.
OUT-OF-NETWORK	75% after deductible.	60% after deductible.	80% after deductible.

WHAT'S COVERED UNDER HOME HEALTH CARE

Note that only medically necessary services that are prescribed by the attending physician and under the supervision of the attending physician are covered. The following is a partial list of health services available through a Home Health Care Agency:

- Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if services of a registered nurse are unavailable;
- Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse;
- Physical therapy, speech therapy, medical social work and nutritional consultations provided by the Home Health Care Agency; and
- Medical supplies, medications prescribed by a physician and laboratory services by or on behalf of the Home Health Care Agency to the extent such items would have been covered if the insured had remained in the hospital. Visits must be medically necessary.

HOSPICE CARE

Hospice care is covered through the PPO. A hospice is a facility that provides care and services for the terminally ill and that:

- Provides 24-hour a day nursing care for the terminally ill person with necessary physical, psychological and spiritual needs, with acute inpatient and outpatient care, home care, bereavement counseling directly or indirectly;
- Has a medical director who is a physician;
- Has an interdisciplinary team that coordinates the care and services it provides and that includes at least one physician, one registered professional nurse and one social worker;
- Maintains central clinical records on all patients; and
- Is licensed or accredited as a hospice if required.

You must obtain prior authorization from BCBSMA for hospice care to be provided in the home.

HOSPICE CARE	PLAN I	PLAN II	RETIREE HEALTH BENEFITS PLAN
PPO NETWORK	80% after deductible *Prior authorization required for home hospice care only*	70% after deductible *Prior authorization required for home hospice care only*	100% after deductible *Prior authorization required for home hospice care only*
OUT-OF-NETWORK	75% after deductible *Prior authorization required for home hospice care only*	60% after deductible *Prior authorization required for home hospice care only*	85% after deductible *Prior authorization required for home hospice care only*

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

The Fund provides certain coverage under Plan I, Plan II and the Retiree Plan for treatment of mental health and substance abuse for you and your eligible dependents. For more details on benefits under each Plan, refer to the Schedule of Benefits beginning on page 97.

PRIOR AUTHORIZATION REQUIRED FOR INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE CARE.

If your doctor recommends inpatient care, partial hospitalization or intensive outpatient care for the treatment of mental health or substance abuse, you, your doctor or a family member must obtain pre-approval by calling BCBSMA at 800-327-6716 before your admission.

Inpatient Care

If hospitalization or residential treatment is required and you go to a network facility, you pay:
Plan 1 - 80% after deductible
Plan II - 70% after deductible
Plan III - $250 copay per admission then 80%

In an Emergency

In a mental health emergency, the patient should first go to the nearest emergency room and then contact BCBSMA at 800-327-6716.

Outpatient Care

Benefits for outpatient mental health or substance abuse treatment from a network provider are generally paid at 100%, after you pay a $15 copay per office visit. For partial hospitalization and intensive outpatient treatment benefits, see the Schedule of Benefits, beginning on page 97.

The Carpenters Assistance Program Can Help

If you need substance abuse treatment, call the Carpenters Assistance Program (CAP) first. CAP will explain the different treatment options available to you so you can make the most of what the Health Benefits Fund offers. CAP is confidential and free to participants and their families. Call 800-344-1515, extension 1160; or contact Paul Greeley at 978-752-1160.

CAP also offers help to you and family members dealing with stress, depression and other personal issues. See page 23 for details.

WHAT'S NOT COVERED

A comprehensive listing of the Fund's general exclusions appears on page 69.

CARPENTERS CARE

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

The Carpenters Center is the Boston-based home to Carpenters Care—important programs just for Carpenters and their dependents:

- The Carpenters Assistance Program
- The Carpenters Vision Center / Vision Benefits

Carpenters Assistance Program (CAP)

The Carpenters Assistance Program (CAP) provides free, confidential assistance for you and your family members confronting stress, depression, job or family problems and substance abuse and addiction.

CAP: A BROTHER TO HELP WITH SUBSTANCE ABUSE AND ADDICTION

CAP provides extra help for participants and their families experiencing a substance abuse disorder by helping them obtain alcohol and drug treatment at a reasonable and fair cost. Here are some of the services offered; some conveniently located at Carpenters Care at 750 Dorchester Avenue, Boston:

- Referrals to a local addiction center
- Coordination of care under your Health Benefit Plan
- Standing AA/NA meetings every Tuesday at Carpenters Care from 7 PM – 8 PM
- Access to facilities for homelessness
- Family conflict and/or domestic violence prevention

If you or someone in your family is in need of help for alcohol or substance use, contact Paul Greeley at 978-752-1160 or toll-free at 800-344-1515 ext. 1160—anytime, day or night.

EMPLOYEE ASSISTANCE PLAN THROUGH KGA: PROVIDING HELP FOR LIFE'S CHALLENGES

CAP also works in partnership with KGA and its provider network to help you and your family members cope with a variety of work/life issues. Our partner KGA offers participants and their families confidential access to a range of professionals for help with:

- Anxiety, depression, and addiction
- Relationship and family problems
- Financial counseling
- Anger management
- Eating disorders
- Legal issues
- Job stress
- Grief

Call KGA 24/7 at 800-648-9557 for a confidential consultation or visit online at http://links.kgreer.com/carpenters.

KGA is designed to help you with issues that can be dealt with through short-term counseling (up to eight sessions). For issues that need long-term counseling, the mental health benefits available through the Health Fund are more appropriate. The CAP can help you navigate the resources available to you through your medical benefits and the community.

SERVICES KGA OFFERS:

- **Stress Reduction.**
  Assessment of stress, burnout and mental health issues; resources for stress reduction including online meditation podcasts.
- **Crisis Counseling.**
  Immediate intervention including suicide and violence prevention.
- **Short-term Counseling.**
  Problem solving counseling for adults with all types of issues including individual and family situations.
- **Career Assessment.**
  Interest testing and career exploration services.
- **Childcare Resources.**
  Research and referral for all types of child care needs.
- **Eldercare Resources.**
  Research and referral to meet the needs of your elders.
- **Legal Assistance.**
  Legal consultation and/or attorney referral for most legal issues.
- **Financial Consultation.**
  Help with money management and most financial concerns.
- **Nutrition Consultation.**
  Telephone consultation with nutritionists and dieticians.
- **Work-life Resources.**
  Research and referral to convenience services to help with balancing work and personal life.

Carpenters Vision Center / Vision Care

We know Carpenters have unique vision needs, including special eye protection. In fact, your vision health is so important, the Fund created the Carpenters Vision Center more than 30 years ago exclusively for you and your family. Since 2010, the Center is conveniently located at Carpenters Care. The Carpenters Vision Center participates with Davis Vision—the Fund's vision network provider.

CARPENTERS VISION CENTER

The Carpenters Vision Center is a full-service vision care facility, 100% owned and operated by our own New England Carpenters Health Benefits Fund, and features:

- **Optometrists who perform routine and in-depth exams, and treat patients with more complex medical issues**
- **A contact lens specialist**
- **A wide selection of frames—the largest available under the Plan**
- **Optical services that aren't provided under the Plan, but are available at discounted rates only at the Carpenters Vision Center (for example, special lens materials and coatings)**
- **Fittings available by appointment**
- **Home delivery of glasses and contacts**
- **Dedicated coordination with network providers, especially for our retirees out of the area.**

THE IMPORTANCE OF REGULAR VISION CARE

Regular eye exams can detect and treat cataracts, diabetic retinopathy, glaucoma, and macular degeneration, all of which can cause vision loss or even blindness. Because vision problems often go hand in hand with diabetes, poor hearing, high blood pressure and heart problems, vision care can often detect other health issues.

See the Schedule of Benefits beginning on page 97 for details on what's covered and the benefits available.

Carpenters Vision Center Contact Information

Call the Carpenters Vision Center at 617-782-0100 if you have questions or to make an appointment.

Hours

Monday:	8:30 AM – 4:30 PM *(to schedule appointments only)*

Appointment times are available Tuesday through Saturday—call to schedule your appointment.

Tuesday:	11:00 PM – 7:00 PM
Wednesday:	12:00 PM – 8:00 PM
Thursday:	11:00 PM – 7:00 PM
Friday:	8:30 AM – 3:00 PM
Saturday:	8:00 AM – 4:00 PM
Sunday:	Closed

Please note these hours are subject to change.
Please call 617-782-0100 for an appointment

Location

750 Dorchester Avenue, Boston, MA 02125

Parking is available onsite, or take the Red Line to the Andrew Square T-station—the Carpenters Vision Center is just steps away from the station.

RETIREES AND SURVIVING SPOUSES MUST CALL THE CARPENTERS VISION CENTER FIRST!

Call the Carpenter Vision Center 617-782-0100 before using your vision benefits if you are a:

- **Retired participant (or a spouse) who is collecting a pension from the New England Carpenters Pension Plan, or the UBC Carpenters Pension Plan, and maintaining their union membership.**
- **A surviving spouse who is receiving the pension of a retired participant who was a union member at the time of his or her death.**

IF YOU CHOOSE TO USE A DAVIS VISION PROVIDER

Davis Vision Network Providers

We encourage you to obtain your vision care from the Carpenters Vision Center because you'll receive the greatest value for vision services. However, you can receive vision care through another participating Davis Vision provider if you choose.

Davis Vision is a network of private doctors under contract to provide routine eye exams and eyeglasses or contact lenses. Davis Vision offers a select group of eyeglass frames. **Note: When using the Davis Vision network, you must obtain your examination and glasses at the same time and from the same provider.**

To find a Davis Vision provider, call Davis Vision at 800-999-5431 or visit www.davisvision.com, and click "Find a Provider." Be sure to choose a full-service doctor who can provide both the exam and eyeglasses or contact lenses. When you make your appointment and at the time of your visit, tell the staff that you are in the Davis Vision program through the New England Carpenters Health Fund.

If you are retired, you must contact the Carpenter Vision Center (617-782-0100) before contacting Davis Vision.

The PPO network ophthalmologists are covered under the medical portion of the Plan for vision care other than preventive vision screenings.

Out-of-Network Provider: Optional Vision Benefit

(available only to Plan I and Plan II)

You'll receive the greatest value if you visit the Vision Center for your vision care. However, if you still choose to use an out-of-network provider, you must pay the provider in full up front, then file a claim for benefits. Note that out-of-network vision benefits are not available to retirees and their spouses or surviving spouses.

The Plan pays a partial reimbursement up to the following maximums for certain services received out-of-network. Reimbursement is as follows, regardless of the fee the provider charges:

- Eye exam (routine)—$50
- Frames (one pair only)—$40
- Eyeglass lenses (one pair only)—$60

Note: No contact lens benefit is available through an out-of-network provider.

WAIVING VISION COVERAGE

Please note that your participation in the Health Fund automatically includes vision care coverage. However, a participant may choose to waive vision coverage by notifying the Plan in writing. The participant may then reinstate vision coverage by submitting a written request to the Plan. Coverage will resume only after the Fund Office receives this written request.

QUESTIONS ABOUT VISION COVERAGE?

Call the Carpenter Vision Center 617-782-0100 or the New England Carpenters Health Benefits Fund Office if you have questions (800-344-1515).

PRESCRIPTION DRUGS AND DENTAL

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

- Prescription Drug Benefits (for all Plans)
- Dental Benefits (for Plan I only)

Prescription Drugs

The prescription drug benefit offers you and your family a convenient and cost-effective way to receive your prescription medication either through an Express Scripts network retail pharmacy or by mail. Specialty medications are administered by Diplomat Pharmacy. Benefits under the Fund do not coordinate with another plan's prescription drug benefits.

HOW YOUR PRESCRIPTION DRUG BENEFITS WORK

You and the Fund share the cost of expenses for covered medications. The following chart shows the coinsurance you pay for covered prescription drugs under the Plan, subject to a minimum and maximum dollar amount. As the chart shows, benefits for prescription drugs depend on whether or not the prescription is filled with a drug that is on the Express Scripts "formulary," or is a specialty medication. The Express Scripts drug formulary is an extensive list of generic and preferred brand name prescription medications that have been tested for quality and effectiveness. See page 31 for more information.

	GENERIC	PREFERRED BRAND	NON-PREFERRED BRAND (not on the Plan's formulary)	SPECIALTY (filled through Diplomat Pharmacy)
RETAIL NETWORK PHARMACY (up to 34-day supply)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
MINIMUM/ MAXIMUM	$10minimum/ $20 maximum	$25 minimum/ $50 maximum	$40 minimum/ $80 maximum	$150 minimum/ $300 maximum
MAIL-ORDER (90-day supply)	30% coinsurance	30% coinsurance	30% coinsurance	N/A
MINIMUM/ MAXIMUM	$25 minimum/ $50 maximum	$63 minimum/ $125 maximum	$100 minimum/ $200 maximum	N/A

IMPORTANT!

You can receive up to three fills of a covered long-term drug at a participating retail pharmacy for your retail coinsurance payment. After the third fill, you'll pay the full cost of the prescription if you continue to fill it at a retail pharmacy. You'll pay only a mail-order coinsurance amount if you start using the Express Scripts pharmacy℠. Long-term drugs are those taken regularly to treat conditions such as high blood pressure, high cholesterol and asthma. This requirement does not apply to specialty drugs.

Deductible

There is no deductible to meet before the Plan pays benefits for covered prescription drug expenses.

Annual Out-of-Pocket Maximum for Prescription Drug Expenses

For Plan I, Plan II and the Retiree Health Benefits Plan (Plan III) the annual out-of-pocket maximum for prescription drug expenses is $3,600 for participant-only coverage and $7,200 for family coverage. This means that once the amount you pay for prescription drugs reaches the limit, the Plan will pay covered medication expenses for the rest of the Plan year.

Coinsurance

You pay a percentage of the negotiated price for prescription medications. Your cost has a minimum and maximum dollar amount for each prescription, as shown in the chart on the previous page.

Retail Pharmacy

You can use your Express Scripts ID card to fill prescriptions at any participating Express Scripts retail pharmacy. The Plan does not provide out-of-network coverage.

MAIL-ORDER PHARMACY

The mail-order drug program is a cost-effective way to get medications you take on a regular basis. The Plan has a mandatory mail-order program for maintenance medications (or those you take regularly). You will receive benefits for one fill of a covered maintenance medication plus two refills at a network retail pharmacy. After that, to receive coverage, you must order your maintenance medication through the mail, or pay 100% of the cost of the prescription at a retail pharmacy.

To fill a prescription by mail, submit a prescription for a 90-day supply with an Express Scripts mail-order form. For the form, visit www.Express-scripts.com, or call Express Scripts at 800-939-3750.

USING THE MAIL-ORDER PROGRAM FOR THE FIRST TIME

Follow the steps below, or call Express Scripts and tell them the prescription drug you are taking regularly. They can contact your doctor to obtain the prescription for maintenance medication for you.

STEP 1. **If you're having your prescription filled for the first time, ask your doctor to write out two prescriptions—one for a 34-day supply you can fill at a network retail pharmacy and the other prescription for a 90-day supply with three refills that you can send to Express Scripts Mail-Order. The prescription must include:**

- **patient's name**
- **doctor's name, address and phone number**
- **exact strength, quantity and dosage**
- **diagnosis, if required for that drug.**

Note that your doctor can also email or fax the prescription directly to Express Scripts on your behalf.

STEP 2. **Contact Express Scripts for a mail-order form. Go to www.Express-Scripts.com and download the mail-order form.**

STEP 3. **Complete the form and mail it, along with your prescription (written for a 90-day supply and three refills) to Express Scripts at the address provided on the form.**

STEP 4. **Your 90-day supply of medication should arrive within two weeks.**

STEP 5. **When you receive your prescription, you'll receive information about how and when to reorder refills, or take advantage of the automatic refill program.**

GENERIC DRUGS

The Health Benefits Fund encourages the use of generic drugs. Generic drugs are a less expensive alternative to brand name drugs. The generic version of any drug contains identical active chemical ingredients and must meet the same manufacturing standards and federal requirements for safety and effectiveness as a brand name drug. Your copayments for generic drugs are lower whether you use a retail pharmacy or order your prescription drugs by mail.

If the generic drug does not provide the same outcome for you as you may have with the brand name version, the Fund Office will work with you and your doctor to receive the appropriate medication to treat your condition at the appropriate copay. Please note prior authorization for a brand name drug is required.

FORMULARY

The Plan includes a formulary—a list of preferred drugs that are either more effective at treating a particular condition than other medications in the same class of drugs, or just as effective and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. The formulary is updated periodically and subject to change. To get the most up-to-date list, visit www.express-scripts.com.

Formulary Changes and Prior Authorization

To help control prescription drug costs and to help maintain the long-term viability of the Plan's prescription drug program, from time to time the Trustees may agree to accept changes to Express Scripts' formulary. Examples of how the formulary can change are:

- A drug may be moved to a higher or lower cost-sharing formulary tier.
- Additional drugs may be excluded from the formulary.
- A restriction may be added on coverage for a drug that is on the formulary.
- A formulary-covered brand name drug may be replaced with a formulary-covered generic drug.

Be sure to check before you purchase the drug to make sure it is covered on the formulary—you may not receive notice that a drug has been removed from the formulary. Certain drugs—even if on the formulary—will require prior authorization. If you have been prescribed a prescription drug that the Plan ceases to cover because Express Scripts removes the prescription drug from its formulary, you should receive notice in writing of such change; however, the change will become effective even if you do not receive notice prior to the effective date of such change.

If a Drug Is Excluded from the Formulary

Drugs that are excluded from the Plan's formulary are not covered under the Plan unless approved in advance through a formulary exception process managed by Express Scripts. To be approved, a drug must be:

- Medically necessary and essential to the covered person's health and safety; and/or
- All formulary drugs comparable to the excluded drug must have been tried by the covered person.

If approved through that process, the applicable formulary copay would apply for the approved drug based on the Plan's cost-sharing structure.

If the drug is not approved, and/or if the covered person selects drugs that are excluded from the formulary, the full cost of the drug without any reimbursement would apply. If your physician believes that an excluded drug meets the requirements for approval, he or she should initiate a formulary exception review by calling Express Scripts.

STEP THERAPY

When multiple drugs are available to treat the same condition, the Plan requires participants to try frontline (first step) medications which are clinically effective, lower-cost drugs before they "step up" to a higher-cost medication.

COMPOUND DRUGS

The Board of Trustees adopted an excluded ingredient list for compound drugs that went into effect on January 1, 2015. The compound drug exclusion list is available upon request from Express Scripts. This may be subject to change.

SPECIALTY DRUGS

Specialty medications are powerful, expensive drugs used to treat certain serious medical conditions such as certain types of cancer, hemophilia, immune deficiency, multiple sclerosis, hepatitis C and rheumatoid arthritis. These are typically self-injectable, infusible or complex oral medications.

If you take specialty drugs, you must fill your prescription through Diplomat Specialty Pharmacy. For a list of covered specialty drugs, or for more information about specialty drug coverage, visit www.diplomatpharmacy.com or contact Diplomat at 888-514-5156.

If you are diagnosed with a serious condition that requires specialty medications, your doctor will work with Diplomat Specialty Pharmacy to obtain the appropriate authorization before the prescription is filled. Once a prescription has been approved, it is typically delivered to you via your home address (or your doctor's office, depending on how the medication will be administered).

COVERAGE OF CERTAIN OVER-THE-COUNTER (OTC) DRUGS

For an over-the-counter drug to be covered by the Plan, the drug must be presented to the pharmacist at a network retail pharmacy, with a prescription for the OTC drug from your health care provider. (Note that while these OTC drugs require a prescription, certain types of insulin are payable by the Plan without a prescription).

OTC DRUG NAME	WHO IS COVERED FOR THIS DRUG?	YOUR COST-SHARING?	PAYMENT PARAMETERS (for generic OTC drugs) in addition to a prescription from your physician or health care practitioner
Aspirin	• For men 45-79 years of age to reduce chance of a heart attack • For women 55-79 years of age to reduce the chance of a stroke • For pregnant women who are at high risk for preeclampsia (a pregnancy complication)	None, if payment parameters are met	For non-pregnant adults: since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months. Daily low-dose aspirin (81 mg) as preventive medication after 12 weeks' gestation in pregnant women who are at high risk for preeclampsia.
OTC contraceptives for females, such as spermicidal products and sponges	All females	None, if payment parameters are met	Up to a month's supply of prescription contraceptives per purchase (or 3-month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program (for females younger than 60 years of age). Generic FDA-approved contraceptives are at no cost to the Plan participant. Brand contraceptives are payable only if a generic alternative is medically inappropriate.

OTC DRUG NAME	WHO IS COVERED FOR THIS DRUG?	YOUR COST-SHARING?	PAYMENT PARAMETERS (for generic OTC drugs) in addition to a prescription from your physician or health care practitioner
Folic acid supplements containing 0.4 – 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily folic acid supplement	None, if payment parameters are met	Excludes women over 55 years of age, and products containing more than 0.8mg or less than 0.4mg of folic acid. Plan covers generic folic acid up to one tablet per day.
Iron supplements	For children ages 6-12 months who are at increased risk for iron deficiency	None, if payment parameters are met	OTC coverage excludes intravenous iron products and bulk iron products.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months.
Tobacco cessation products (FDA approved)	Individuals who use tobacco products	None, if payment parameters are met	FDA-approved tobacco cessation drugs (including both prescription and over-the-counter medications) are payable under the plan's Prescription Drug Program, for up to two 90-day treatment regimens per year, which applies to all products. No prior authorization is required.
Fluoride supplements	For preschool children older than age 6 months when recommended by provider because primary water source is deficient in fluoride	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and brand name fluoride supplements.
Preparation "prep" Products for a colon cancer screening test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy (for individuals age 50-75 years).

The chart above outlines the OTC drugs that are payable by the Plan **at no charge when purchased at the Plan's network retail pharmacy location or mail-order service**, in accordance with health reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released regulations affecting the coverage of OTC drugs, this Plan will comply with the new requirements on the date required.

Prescription Drug Fraud and Abuse

Please note that Express Scripts monitors prescriptions for fraud and abuse and may alert the Fund Office of any detected fraud or abuse situations.

Dental Care – for Plan I Only

Regular dental care is an important part of staying healthy. That's why the Health Benefits Fund offers comprehensive dental benefits, including orthodontia, through Delta Dental, the nation's largest dental network. Please note that dental benefits apply only to Plan I participants.

- Dentists who participate in the Delta Dental network have agreed to provide services at a pre-negotiated discounted rate. When you visit a Delta Dental provider, show your Delta Dental ID card to receive the discounted rates.
- To find a Delta Dental participating provider, call Delta Dental Customer Service at 800-872-0500 or visit www.deltadentalma.com.

The chart on page 104 shows the amount the Plan pays for dental care through the Delta Dental network.

HOW YOUR DENTAL BENEFITS WORK

Deductible

There is no annual deductible to meet before the Plan pays for covered dental services.

Annual Benefit Maximum

A $2,500 calendar year maximum dental benefit applies to each covered person for dental services.

The lifetime maximum benefit for orthodontia is $2,000 per covered person. There's no age limit for orthodontia.

Implants - Once every 60 months (Pre-estimate recommended) Bone Grafts - Once per 60 months, covered when placement is at an extraction or implant site.

These services are considered major restorative and covered at 50% and is applied towards the calendar year maximum of $2,500.

Plan Benefits

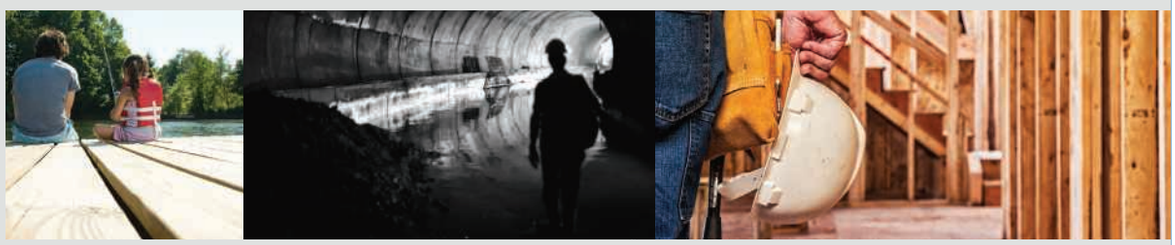
The chart on page 104 shows the benefits payable when you use a participating Delta Dental provider, and if you go out of network. Please refer to your Delta Dental benefits guide for more specific coverage information, or visit www.deltadentalma.com.

QUESTIONS ABOUT WHAT'S COVERED?

Contact Delta Dental Customer Service at 800-872-0500 for information about limitations or exclusions that may apply to a particular procedure.

LIFE, AD&D, AND DISABILITY BENEFITS

NEW ENGLAND CARPENTERS



HEALTH BENEFITS FUND

This section includes information about:

- Life Insurance;
- Accidental Death and Dismemberment (AD&D) Benefits; and
- Weekly Accident and Sickness Benefits.

Life Insurance (Plans I & II)

The Fund provides life insurance coverage to participants who meet the Plan's eligibility requirements and are covered under Plan I or Plan II through worked hours, including Short Hours Buy-In or a disability extension. Coverage includes a lump sum benefit for your designated beneficiary in the event of your death, and a benefit for you in the event of your spouse's death. The Fund also provides a benefit to participants who suffer a severe bodily loss in an accident.

WHAT TO DO

- **Be sure to designate a beneficiary for your life insurance benefit.**
- **Keep your beneficiary designation up to date. Certain life events may cause you to want to change your beneficiary— for example, marriage, birth or death. Contact the Fund Office to update your beneficiary.**
- **In the event of death, your beneficiary should contact the Fund Office and provide a certified copy of your death certificate in order to receive a benefit.**

LIFE INSURANCE			
BENEFIT	PLAN I	PLAN II	RETIREE HEALTH BENEFITS PLAN
Participant Life Insurance (payable to your beneficiary)	$20,000	$20,000	No benefit
Spouse Life Insurance (payable to you)	$2,000	$2,000	No benefit

NAMING A BENEFICIARY

You may name anyone you wish to be your beneficiary and you may change this designation at any time. You should also name a contingent beneficiary to receive your benefit in the event your primary beneficiary is not living at the time of your death.

To change your beneficiary, call the Fund Office for the appropriate form. You do not need to get your beneficiary's consent to make this change. Your change will be effective when the Fund Office receives your completed form.

Your beneficiary designation must be on file at the Fund Office at the time of your death to be valid.

If you do not have a designated beneficiary form on file at the Fund Office at the time of your death, or if your designated beneficiary does not survive you, your life insurance benefit will be paid to your estate.

COVERAGE FOR YOUR SPOUSE

The Fund also provides a life insurance benefit for your spouse. If your current legal spouse dies from any cause while covered under the New England Carpenters Health Benefits Fund, you, as the participant, will be eligible for a lump sum benefit of $2,000. Note that ex-spouses are not eligible for this benefit.

KEEP YOUR BENEFICIARY INFORMATION UP TO DATE

Contact the Fund Office to change your beneficiary if you get married, have a child or get divorced.

CONTINUING COVERAGE IF YOU BECOME DISABLED

If you become totally and permanently disabled while you're covered under the Health Benefits Fund, your life insurance coverage will be continued at no cost to you unless you recover from your disability or attain age 65. You must complete and file an application for total and permanent disability with the Fund Office within one year of the date you become disabled and prior to your 60th birthday. The Fund Office will require proof of your continued disability to keep your life insurance in force. Contact the Fund Office to request an application.

EXTENDED BENEFITS

If you die within 31 days from the date your coverage under the New England Carpenters Health Benefits Fund ends, the full amount of life insurance will be payable to your beneficiary.

CONVERTING YOUR COVERAGE

In certain cases, you may be able to convert life insurance coverage to an individual policy within 31 days of your eligibility under the Health Benefits Fund ending.

For an application for conversion, contact Unum (the Fund's life insurance provider) directly within 31 days of the date your coverage ends.

Accidental Death and Dismemberment (Plans I & II)

Accidental Death and Dismemberment (AD&D) Insurance provides a benefit for Plan I and II participants for accidental loss of life, limbs or eyesight while you are covered by the New England Carpenters Health Benefits Fund through worked hours, including Short Hour Buy-In or a disability extension.

- This benefit is available for the participant only; dependents are not covered under the AD&D benefit.
- The AD&D benefit is payable in addition to and separate from the life insurance benefit.
- Benefits are payable if the loss is a direct result of any injury caused by an accident.

The chart below shows the amount that is payable to you in the case of accidental dismemberment. In the event of your death, the benefit is payable to your designated beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR PARTICIPANT ONLY		
	PLAN I	PLAN II
Loss of life or loss of movement of both upper and lower limbs (quadriplegia). Loss of both hands or both feet or sight of both eyes	$20,000	$20,000
Loss of one hand, one foot, speech or hearing in both ears, or either one hand or one foot and sight of one eye	$20,000	$20,000
Loss of movement of three limbs(Triplegia) or both lower limbs (Paraplegia)	$15,000	$15,000
Loss of a hand, a foot, an eye, speech or hearing. Loss of movement of both upper and lower limbs on one side of the body (hemiplegia)	$10,000	$10,000
Loss of thumb and index finger on either hand or loss of movement of one limb (uniplegia)	$5,000	$5,000

"Loss" means the following:

- Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint.
- Loss of an eye means that sight in the eye is completely lost and cannot be recovered or restored.
- Loss of speech or hearing means that speech or hearing is lost entirely and cannot be recovered or restored. Hearing must be lost in both ears.
- Loss of movement of limbs means that the movement is completely lost and the loss is irreversible.
- Loss of thumb and index finger means actual severance through or above the metacarpophalangeal joints.

WHAT'S NOT COVERED

The Fund will not pay an AD&D benefit for death or any loss resulting from or caused directly, wholly or partly by:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the diagnostic and statistical manual of mental disorders.
- War, declared or undeclared, or any act of war.
- Active participation in a riot.
- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- operating any motorized vehicle while intoxicated.
- the voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's physician. This exclusion does not apply to you or your dependent if the chemical substance is ethanol.
- An attempt to commit or commission of a crime.

ADDITIONAL BENEFIT

Unum provides additional benefits for use of seat belt and airbags in a motor vehicle accident, as well for comas and critical burns. There are also benefits for spouse and child education, day care, rehabilitation, and repatriation of remains. For more information on these benefits, contact Unum (the Fund's accidental death and dismemberment insurance provider).

Disability: Weekly Accident and Sickness (Plan I Only)

If you become totally disabled and cannot work due to a non-work related injury or illness, you may be eligible for a weekly accident and sickness benefit through the New England Carpenters Health Benefits Fund. This benefit is only available to participants in Plan I based on worked hours, including Short Hours Buy-In or disability extension.

If you are receiving a benefit under Workers' Compensation, unemployment benefits, or Occupational Disease Law or similar legislation, you are not eligible for the Weekly Accident and Sickness benefit.

WHAT IS TOTAL AND PERMANENT DISABILITY?

The Health Benefits Fund considers you totally and permanently disabled if you are not working at any job for wage or profit, and you are unable to work in any job that is reasonably suited to you by your education, training or experience due to an illness or injury.

PAYMENT OF BENEFITS

Contact the Fund Office as soon as you know you will be out of work for at least eight days due to a non-job-related disability. The Fund will advise you on filing a claim for benefits.

Once your claim is received and eligibility for a benefit is confirmed, a benefit payment will begin as soon as administratively possible, retroactive to the first day of disability for a non-work-related injury, or the eighth day of disability due to an illness.

Successive periods of disability that are separated by less than two weeks of continuous active covered employment are considered one period of disability. If you suffer another disability due to a different and unrelated cause, you must return to active work for a period of more than two weeks to receive a benefit for another period of disability.

WHEN BENEFITS BEGIN	DAY 1 (ACCIDENT)	DAY 8 (ILLNESS)
Maximum Benefit ($500 per week)	26 weeks	26 weeks

Payment will continue during your disability for a maximum of 26 weeks for any one continuous period of disability due to the same or related cause or causes, provided you remain disabled and submit the requested paperwork from your provider in a timely manner, subject to approval by the Plan.

It is not necessary for you to be confined to your home in order to collect a weekly accident and sickness benefit, but you must be under the care of a legally qualified physician licensed to practice medicine, and continue to meet the definition of total disability (above).

PREGNANCY-RELATED DISABILITY

If you are totally disabled and medically unable to work because of pregnancy, childbirth or miscarriage, your weekly accident and sickness benefit is payable from the eighth day of disability on the same basis as any other illness. Note that pregnancy through surrogacy is not covered under the Fund; see the General Exclusions tab.

PLEASE NOTE

- **Payments you receive from the weekly accident and sickness benefit are considered taxable income and must be reported on your federal income tax return. The Fund Office will withhold state and federal income taxes.**
- **No Social Security (FICA) tax is deducted from your payment. The Fund pays this tax for you.**
- **If your disability is related to a motor vehicle accident, the Fund does not pay until the benefit from the automobile insurance has been exhausted.**
- **If your disability is due to an injury but you do not stop working at the time of the injury, the disability is considered an illness and the waiting period applies.**
- **It is your responsibility to provide updates of your condition to the Fund Office.**

IF YOU'RE INJURED ON THE JOB

If you become disabled due to a work-related illness or injury, you may be eligible for a Workers' Compensation benefit. Contact your employer or Local for information on how to apply for benefits.

LIFE EVENTS

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

Life Events

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when you experience certain "life events" and what you must do to make sure you get the most from your coverage.

FAST FACTS

- **You should notify the Fund Office as soon as possible if you experience a life event (marriage, birth, etc.).**
- **You must provide the Fund Office with the proper documentation to add your new spouse or dependent within six months of the life event to ensure that your dependent will receive coverage dating back to the date the life event occurred. Coverage may be denied if documentation is not provided in a timely manner.**
- **You and/or your dependents may qualify to continue coverage under COBRA in the event of a loss of eligibility, divorce, or your termination or reduction of your work hours. See page 61 for information on COBRA.**
- **If you become disabled, you may be entitled to receive an extension of coverage for up to 12 months.**

IMPORTANT!

If you provide the required information within six months of the life event (marriage, birth, adoption or legal guardianship), your spouse and/or child will be eligible for coverage under the Fund as of the date of the life event. If you provide documentation of the life event six months or later from the actual date of the event, coverage may begin the first of the month following the receipt of the documentation, subject to review by the Trustees, unless extenuating circumstances prevented you from submitting the documentation in a timely manner.

YOU MUST COMPLETE A HEALTH DEPENDENT ENROLLMENT FORM TO ENROLL A NEW DEPENDENT

All participants must complete a Health Dependent Enrollment form in order to enroll a new dependent, in addition to any specific documents the Fund Office requires. Any additional required documents are outlined in this section.

Note that the Health Dependent Enrollment Form requires you to provide a Social Security number for all eligible dependents for whom you are enrolling (or have enrolled) in the Plan. If a dependent does not yet have a Social Security number, you can go to www.socialscecurity.gov/online/ss-5.pdf for a form to complete to apply for a Social Security number. Contact the Fund Office for a Health Dependent Enrollment Form.

IF YOU BECOME NEWLY ELIGIBLE FOR COVERAGE FOR THE FIRST TIME

If you are a newly eligible participant in the Plan, defined as a participant who has gained eligibility for coverage for the first time under this Plan, you have 60 days from the date you became eligible to enroll your dependents. To enroll your dependents, you must complete a Health Dependent Enrollment form and provide the Fund Office with the proper documentation within your enrollment deadline. For example, if you become eligible for coverage on April 1, you have until May 31 to enroll your dependents.

IF YOU GET MARRIED

If you get legally married, you must provide the Fund Office with the following information:

- A copy of your marriage certificate, available from the town or city hall where you were married;
- A completed Health Dependent Enrollment Form (which will ask for your spouse's date of birth and Social Security number); **and**
- A copy of your spouse's medical insurance information, if he or she is covered under another group insurance plan, so benefits can be coordinated between this Plan and his or her other coverage. For more information, see "Coordination of Benefits" on page 55.

Update your beneficiary designations:
If you wish to name your spouse as your beneficiary for your life insurance and accidental death and dismemberment benefit, contact the Fund Office for a "Beneficiary Designation" form. Please note that marriage does not automatically entitle your spouse to these benefits upon your death. You must have a named beneficiary on file.

IF YOU NEED TO ADD A CHILD TO YOUR COVERAGE

IMPORTANT!
Expenses related to a surrogacy pregnancy are excluded from the Plan (see page 70).

You must provide the Fund Office with the following information:

- A copy of the child's birth certificate listing both parents;
- A completed Health Dependent Enrollment Form (which will ask for the child's date of birth and Social Security number)
- A copy of the child's other medical insurance information if he or she is covered under another group insurance plan (such as through your spouse).

IMPORTANT!
Notify the Fund Office if your child reaches age 26, becomes eligible for other medical coverage through his or her job or if your child dies.

In addition to the above documents, you must also include:

If the child is your stepchild:

- A marriage certificate **and**
- The divorce decree if the child's natural parents were married and divorced, **or**
- A court order or written statement indicating whether the natural mother and/or father have health insurance for the child, **or**
- The death certificate of the natural parent if he or she has died.

If the child is adopted:

- A copy of the adoption agency paperwork indicating the specific date the child was placed in your home for adoption.

If you are the legal guardian to a child:

- A copy of the court document indicating you are the legal guardian of the child.

IF YOU GET DIVORCED

NOTE: Coverage for stepchildren ends as of the last day of the month before the divorce is final. However, stepchildren would be eligible to continue coverage through COBRA. For more information, see page 61.

If you get legally divorced, you must immediately provide the Fund Office with the following information:

- A copy of your divorce decree and all documents filed with the decree;
- If your divorce decree requires the continuation of health coverage, your former spouse must sign an acknowledgement that if he/she remarries and does not notify the Plan immediately, he/she will be responsible for the cost of any claims following the re-marriage. This acknowledgement must be bank guaranteed or witnessed by a Fund Representative.
- If you have children and you do not have custody, a copy of any Qualified Medical Child Support Order (QMSCO), if applicable. A QMSCO is a court order or decree that may require you to provide health coverage in the event of a divorce. For more information, call the Fund Office.

The Plan may continue coverage for your former spouse if required by the divorce decree. Coverage will begin upon receipt of all documents, provided you have coverage under the Plan and coverage is maintained until the termination date set forth in the order or the date that you or your former spouse remarry, whichever occurs first.

In addition, you must notify the Plan immediately if you remarry, or become aware that your former spouse has remarried. If you fail to notify the Plan immediately, you will be held responsible for the cost of any claims paid on behalf of your former spouse following the remarriage and you may be subject to further sanctions including loss of coverage. Under no circumstances will the Plan cover both the former spouse and a current spouse.

Your former spouse may continue coverage under the Plan by notifying the Fund Office within 60 days of the day that the divorce becomes final. For more information about COBRA, see page 61.

IF YOU BECOME DISABLED

Contact the Fund Office as soon as possible if you can't work due to an injury or illness. If your disability is due to a work-related injury or illness, you may be eligible for Workers' Compensation. (Contact your employer for more information.)

If your disability is not work-related, you may be eligible for Weekly Accident and Sickness Benefit through the Fund for up to 26 weeks. See page 39 for more information.

If your disability will be long-term, you should apply for Social Security Disability as soon as possible. For more information, contact your local Social Security office or visit www.ssa.gov.

If you are eligible for a Social Security Disability Pension, you may be eligible for coverage under the Retiree Health Benefits Plan for up to 24 months or until you are covered by Medicare, whichever comes first.

Generally, if you are approved for Social Security Disability Income (SSDI), you would become eligible for Medicare. For more information on Medicare, see page 46.

Extension of Health Coverage for Disabled Participants

If you become totally disabled during a work period and, as a result of that disability, you do not have enough hours to qualify for coverage, you may be eligible for a disability extension that extends your coverage period under the Plan.

To be eligible, you must have coverage through worked hours including Short Hour Buy-In for either Plan I or Plan II at the time you became totally disabled from work due to injury or illness.

You may be granted coverage for up to two insured periods over the course of your career. They may be used consecutively in connection with one continuing disability, or they may be used on separate occasions in connection with separate disabilities at different times during your career.

Your disability extension would begin once your coverage terminates. If you are eligible for both a disability extension and the Short-Hour Buy-In provision, you have the option to choose one of these provisions for continuing your coverage. Your coverage will be based on the same Plan you had at the time your disability began and you cannot upgrade your coverage. The Fund will require proper documentation to substantiate your disability. Participants beyond age 65 who currently have coverage through worked hours including Short Hour Buy-In for either Plan I or Plan II will be entitled to a disability extension provided all the eligibility requirements have been met.

IF YOU MOVE

Call the Fund Office and speak with the Member Services department for a change of address form. You can also access this form online through the website to print and submit by mail or secure fax. Notifying the Fund of your address change is necessary to keep your records up to date and to avoid a delay in payment of claims.

IF YOU ENTER ACTIVE MILITARY SERVICE

- Notify your employer and the Fund Office immediately; **and**
- Make any required self-payments to the Fund Office to continue your coverage.

If you are on active duty for 31 days or less, you will continue to receive health care coverage for up to 31 days, according to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage under COBRA (see page 61) for you and your dependents at your own expense for up to 24 months. COBRA will be offered after your coverage runs out. Your dependent(s) may be eligible for health care coverage under TRICARE. The New England Carpenters Health Benefits Fund will coordinate coverage with TRICARE (see page 57).

This Fund does not cover any illness or injury determined by the Secretary of Veterans Affairs to have incurred in, or been aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated on the day you return to the Union Office for work with a contributing employer, provided that you return within:

- 90 days from the date of discharge if the period of service was more than 180 days; **or**
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; **or**
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.
- You will be granted the same plan of coverage you had when you began active duty.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

IF YOU TAKE FAMILY MEDICAL LEAVE

If you take leave in certain circumstances such as serious illness, birth of a child, or caring for a seriously ill parent or spouse, your employer may be obligated to continue contributions on your behalf under the Family and Medical Leave Act (FMLA). Talk to your employer for details.

IN THE EVENT OF A DEATH

If there is a death in your immediate family, please call the Fund Office for benefits help including filing a claim form for life and AD&D benefits, if applicable. The Fund Office will need an original copy of the death certificate.

IN THE EVENT OF A DEATH continued

Widow(er) Extension

If a participant dies during an insured period, coverage for the surviving spouse and covered eligible dependent(s) will continue until the insured period ends through worked hours (including disability extension and Short-Hours Buy-In). At that time, the Fund will provide continuing coverage for a surviving spouse and eligible dependents for 36 months at no cost.

To be eligible, the surviving spouse and eligible dependents must not have any other coverage, and they must complete a form with the Fund Office to elect this coverage.

Coverage would continue in either Plan I or Plan II according to what the participant had at the time of death. Former spouses awarded coverage through a divorce decree are not eligible for this extension.

An extension also applies to eligible dependents of deceased retirees. See page 54 for more information.

IF YOU RETIRE / MEDICARE

If you retire, you and your eligible dependents, which are defined on page 51, may be eligible for the New England Carpenters Retiree Health Benefits Plan provided you are under age 65 (not eligible for Medicare), and you meet the Plan's requirements described in the Eligibility section.

The Retiree Health Benefits Plan provides comprehensive medical, prescription drug and vision benefits. For medical benefits, see the chart beginning on page 102. For prescription drug benefits, see page 29; for vision, see page 107.

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

When You Become Eligible for Medicare

Coverage under the Retiree Health Benefits Plan will end when you and/or your spouse turn age 65 and become eligible for Medicare. (If you turn age 65, but your spouse is under age 65, your spouse will remain on the Fund's Retiree Health Benefits Plan for participants under age 65 until they become Medicare-eligible, provided the Plan's eligibility requirements continue to be met.)

Medicare is the federally sponsored health care program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B).

You should enroll in Medicare as soon as you are eligible—three months before your 65th birthday or in certain cases when you become disabled—in order to avoid a gap in coverage.

You're also eligible for Medicare if you are under age 65 and you are awarded Social Security Disability Income, or if you have ESRD (end-stage renal disease, permanent kidney failure treated with dialysis or a transplant) or ALS (Lou Gehrig's disease).

TO ENROLL IN MEDICARE:

- Visit your **local Social Security Office**;
- Call **800-MEDICARE (800-633-4227)**; or
- Go to the Medicare website at **www.medicare.gov**.

ELIGIBILITY FOR

PLAN I, PLAN II AND THE RETIREE HEALTH BENEFITS PLAN

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

Eligibility for Plan I and Plan II

- **You must work a specified number of hours to be eligible to receive benefits for you and/or your eligible dependents.**
- **When you don't work enough hours to qualify for benefits, you may be able to purchase Continuation Coverage under the federal program known as COBRA.**

Your eligibility to participate in Plan I or Plan II is based on the number of hours you work in covered employment and the contributions your employer is required to make to the Fund on your behalf, determined by the hourly contribution rate. These contribution rates are outlined in a Collective Bargaining Agreement between your employer and the New England Carpenters Health Benefits Fund. Contributions to the Fund also include any contributions that are placed in this Fund under a reciprocal agreement by the trustees of another local union for which contributions are authorized.

In addition to Hours Requirements, you must be a member of a Local Union affiliated with the United Brotherhood of Carpenters. If you are dropped from membership by your Local Union, your eligibility for coverage will cease effective the month after which your Local Union membership is terminated. If your Health Benefit coverage is terminated under this rule and you later reinstate your Local Union membership, your Health Fund coverage will be restored, assuming you are otherwise eligible, effective the beginning of the insured period during which your Local Union membership is reinstated. This rule applies to both initial eligibility and maintaining eligibility.

HOURS REQUIREMENTS

Your eligibility for benefits depends on the number of hours you work in covered employment during a six-month "work period." If you work the required number of hours—and your employer contributes to the Fund for those hours—you and your eligible dependents will be eligible for coverage during a six-month "insured period." The hours requirements are listed below:

AREA	PLAN I	PLAN II
Massachusetts, Connecticut and Rhode Island Carpenters, Piledrivers, Floorcoverers and Millwrights (Mass/RI, CT)	600 hours	450 hours
Northern New England Locals 349 and 352	685 hours	510 hours
Northern New England Millwrights	650 hours	485 hours
Woodframe Local 723	685 hours	410 hours
Western Massachusetts Local 336	685 hours	510 hours

WORK PERIODS AND INSURED PERIODS

The hours you work during the work period are used to determine whether you are eligible for coverage during the six-month insured period. The work periods and insured periods are listed below.

WORK PERIOD	INSURED PERIOD
August 1 – January 31 and February 1 – July 31	April 1 – September 30 and October 1 – March 31

MAINTAINING YOUR ELIGIBILITY

Once you achieve eligibility, your coverage will continue as long as you work the sufficient number of hours required in a work period. If you do not work the required number of hours, you may be able to maintain your coverage under one of the following provisions, which are described further (below):

- **Aggregation of hours;**
- **12-Month Lookback (Plan I only);**
- **Short Hour Buy-In;**
- **Apprentice Training Center Hours;**
- **Banked Hours; or**
- **Special Rule for New Participants.**

AGGREGATION OF HOURS

The Board of Trustees has adopted a rule that allows legally married couples the ability to aggregate their hours to secure health eligibility if they cannot obtain eligibility individually based on the hours they have worked. If your hours are combined and you still do not secure coverage, but are within the Short Hour Buy-In provision threshold, you will be offered this option or if you are eligible for the 12-Month Lookback, the rule will be applied to determine your eligibility. Your hours cannot be aggregated to achieve a greater plan of benefits. For example, if one of you works enough hours to achieve eligibility for Plan II, you then cannot aggregate your hours to receive coverage under Plan I.

In order to take advantage of this rule you must apply at each insured period, when necessary, by contacting the Fund Office. You and your spouse will be required to complete a form requesting that your hours be aggregated and the request must be made prior to the insured period.

12-MONTH LOOKBACK

If you do not work enough hours during a work period to be eligible for Plan I, the Fund will combine the hours worked in the current and previous work periods. If you have sufficient hours between the two periods you would be eligible for Plan I. Listed below are the hours required for the 12-Month Lookback.

AREA	PLAN I
Massachusetts, Connecticut and Rhode Island Carpenters, Piledrivers, Floorcoverers and Millwrights (Mass/RI/ CT)	1,250 hours
Northern New England Millwrights	1,350 hours
Northern New England Locals 349 and 352	1,420 hours
Woodframe Local 723	1,420 hours
Western Mass 336	1,420 hours

SHORT HOUR BUY-IN PROVISION

If you do not work enough hours during a work period to obtain or maintain your eligibility, you may purchase Buy-In coverage if you are short by 50 hours or less. You are eligible to purchase the Short Hour Buy-In regardless of whether you had coverage or not in the preceding period. You may have consecutive Short Hour Buy-In periods. For the most up-to-date buy-in rate, contact the Fund Office. The rules for the Short Hour Buy-In provision are listed below.

- Premiums will be billed by the Fund Office in advance of the due date. There will be no additional grace period after such due date. Checks received after the due date will be returned to you.
- Premiums are payable in advance of the eligibility period.
- Payment must be made in one lump sum.
- An individual working elsewhere and eligible for coverage by his employer's group health insurance plan shall not be eligible for a buy-in.
- The premium rate is determined on an annual basis. The Trustees reserve the right to adjust buy-in premiums as necessary.

You have only until the END of April or October to choose this buy-in option. Otherwise, Continuation Coverage would be available under COBRA at COBRA rates. (See page 61 for information on COBRA Continuation Coverage.) If late hours are received and would bring you within the 50 hours required, you would have 30 days from the date of notification to choose this buy-in option.

APPRENTICE TRAINING CENTER HOURS

If you are an apprentice attending school at the Apprentice Training Center and do not work enough hours during a work period, the Plan will grant coverage if you are short 40 hours or less for one week of school or 80 hours or less for two weeks of school. Apprentice Training Center hours cannot be applied toward Short Hour Buy-In, COBRA, or the 12-Month Lookback rule.

BANKED HOURS

Hours that were banked prior to August 1, 1989, will be drawn upon to maintain your coverage when you do not work the required number of hours in a work period.

Therefore, Banked Hours used to maintain eligibility will reduce the actual cost of coverage. Banked Hours can be used only to maintain eligibility through the New England Carpenters Health Benefits Fund and cannot be withdrawn for any other purpose.

Note that for participants other than Western Mass, Banked Hours were credited at $1.90, which was the actual contribution rate in effect at the time the hours were banked. For Western Mass, Banked Hours were credited at $7.50 effective January 1, 2014 through July 31, 2014.

Important points about Banked Hours:

- To maintain your eligibility with Banked Hours, you must have some hours in covered employment during the previous or current work period. You must be eligible to buy into COBRA to exercise this option.
- The use of Banked Hours is required for Short Hour Buy-In, COBRA or the Retiree Health Benefits Plan, if eligible and hours are available.
- Banked Hours will expire if a participant does not have coverage defined as Plan I or Plan II, including Short Hour Buy-In, for six consecutive insured periods.
- Banked Hours will be eliminated upon a participant's death or if a participant retires and does not elect either the Retiree Health Benefits Plan or COBRA.
- The Fund will automatically withdraw the number of hours needed to achieve the best plan available. You may also use Banked Hours to upgrade to Plan I even if you are not within the Short Hour Buy-In threshold.

NEW PARTICIPANTS AND SHOP AND FUND OFFICE EMPLOYEES

Special Rule for New Participants

A new participant is defined as having no hours worked and no coverage under Plan I, Plan II or COBRA for two consecutive years. A new participant may buy into Plan II after working eight hours in the current work period.

If you are a new participant, an eligibility statement with the monthly cost will be mailed to you in March or September (the end of the insured period) indicating the cost for coverage starting the next insured period. Be sure to keep your address current with the Fund Office so you can receive this statement.

Shop and Fund Office Employees (in Plan I Only)

Employers contribute a monthly premium for the hours worked in the current month to be covered for the following month. For example, a participant works enough hours in May therefore is entitled to coverage for the month of June. The number of hours required are set forth in the Collective Bargaining Agreements or Participation Agreements.

OPTING OUT OF DENTAL (PLAN I ONLY) AND VISION COVERAGE

Under the Affordable Care Act, you have the ability to opt out of your dental and vision benefits. The New England Carpenters Health Benefits Fund provides health benefits based on the hours you have worked during a work period, which determines your plan coverage under either Plan I or Plan II for each insured period. Note that only Plan I includes dental coverage.

If you are receiving your coverage under the Retiree Health Benefits Plan, the monthly premiums provide vision benefits (not dental).

The Fund will continue to provide you with dental and/or vision benefits in accordance with your plan coverage unless you contact the Fund to opt out. Keep in mind that opting out of dental and/or vision benefits does not change the hours required for eligibility in Plan I or Plan II and it does not reduce the amount of your monthly premiums whether paid by your employer under a shop agreement or under the Retiree Health Benefits Plan.

WHEN COVERAGE ENDS

Generally, your coverage under the New England Carpenters Health Benefits Fund will end:

- **For Shop Employees, the end of the month following the last month in which you stop working in covered employment;**
- **The date you do not meet the eligibility requirements; or**
- **The date the Plan terminates.**

SPECIAL ENROLLMENT

This Plan complies with the federal law regarding special enrollment by virtue of the fact that all eligible participants and their eligible dependents are automatically enrolled in this Plan as soon as the eligibility requirements of the Plan are met. There is no option to decline coverage. For more information about Special Enrollment under this Plan, contact the Fund Office.

Eligible Dependents

When you become eligible for coverage in the New England Carpenters Health Benefits Fund, your eligible dependents are also eligible for coverage.

Plan's Definition of Dependent

The term "dependent" means:

- your spouse to whom you are legally married
- your child(ren) up to the end of the month in which they turn age 26, including a legally adopted child (or child placed for adoption with you as of the date you first become legally obligated to provide full or partial support of the child you plan to adopt).
- your stepchild or foster child, provided the child depends upon you for support and maintenance and has been reported to the Fund Office.

Note: The term "child" or "children" does not include a child resulting from a surrogate pregnancy.

Surrogacy Not Covered

If the participant or dependent has a surrogate pregnancy, expenses for care relating to the pregnancy and birth are not covered under the Fund, and the child resulting from the surrogate pregnancy is not considered an eligible dependent under the Fund. Please refer to the General Exclusions and Glossary of Terms for details on surrogacy.

Be sure to review the Life Events section for important information about what you need to do if your family situation changes.

IF YOUR CHILD IS DISABLED

If your child is disabled prior to his or her 26th birthday, you can apply for continued coverage. Children are considered disabled when they are primarily dependent on you for financial support and maintenance because of a mental or physical condition that started before age 26.

You must submit proof of your dependent child's disability to the Fund on the later of 31 days after the date he/she attains 26 years of age or 31 days after you are notified of his/her eligibility. Benefits will continue to be provided for your child as long as you remain covered under the Fund, and as long as your child remains disabled. You must provide proof of your dependent child's ongoing disability to the Fund Office annually.

If Your Dependent's Eligibility for Benefits Changes

If your dependent's eligibility status changes due to divorce or your child reaching age 26, you must notify the Fund Office as soon as possible. Your dependent may be eligible for COBRA Continuation Coverage for up to 36 months. See page 61 for more information.

IF YOU ARE A PARTICIPANT AND A DEPENDENT

Note that if you meet the eligibility requirements of a participant (described on page 47), and you can also be considered a dependent of a participant (either a spouse or a child), Coordination of Benefit rules would apply. Refer to the "Coordination of Benefits" section.

Proving Eligibility for Dependents

In general, you are required to complete and submit a Health Dependent Enrollment Form to the Fund Office when adding a new dependent for coverage. The form is available from the Fund Office. You may also be required to submit the following to the Fund Office, depending on your situation:

- Marriage certificate from City Hall or Town Hall;
- Birth certificate document showing both parents' names, court document or written statement on letterhead from appropriate governmental agency showing legal guardianship and date of birth of each child; and
- Divorce decree if applicable.

Refer to the Life Events section of this document for details on adding a dependent to your coverage.

WHEN DEPENDENT COVERAGE ENDS

Your dependent's coverage will end on:

- **The date your child or spouse no longer meets the definition of an eligible dependent under the Fund; or**
- **The date your coverage ends; or**
- **The date the Plan terminates.**

Eligibility for the Retiree Health Benefits Plan

- **The Retiree Health Benefits Plan provides comprehensive medical, prescription drug and vision benefits to eligible retirees and their dependents for up to a maximum of thirty-six months.**
- **Coverage is available to eligible retirees and dependents who are under age 65 and not otherwise eligible for Medicare.**

The Retiree Health Benefits Plan is available for thirty-six months or until you become Medicare eligible whichever occurs first.
The following eligibility requirements apply:

- You retired on or after April 1, 1995 and are receiving a pension benefit from the New England Carpenters Pension Fund **or**,
- Effective October 1, 2014, you are a Shop Participant, with coverage through the New England Carpenters Health Benefits Fund and are receiving a pension benefit from the United Brotherhood of Carpenters Labor Management Pension Fund.

Union membership with your local union is required. In addition, you must also:

- Be eligible for five out of the past 10 insured periods through worked hours under Plan I or Plan II including Short Hour Buy-In or disability extension.
- Be covered under Plan I or Plan II through worked hours, including Short Hour Buy-In or disability extension, in the period immediately preceding your application for retiree coverage.
- Have no other group health insurance, including Medicare.
- Share the cost of coverage with the Fund. Your monthly premiums will increase from time to time.

If you are eligible for a Social Security Disability Pension, you may be eligible for coverage under the Retiree Health Benefits Plan for up to 24 months or until you are covered by Medicare, whichever come first.

Spouse's Eligibility for the Retiree Health Benefits Plan

Your spouse is eligible for coverage under this Plan. If your coverage (defined as Plan I or Plan II, including Short Hour Buy-In) ends after you have attained age 65 and retire, (and therefore become eligible for Medicare), your spouse and any eligible dependent(s) will have the ability to purchase continued coverage under this Plan up to a maximum of thirty-six months or until the spouse attains age 65, whichever occurs first provided:

- Your spouse is under age 65 at the time your active coverage ends (due to retiring); **and**
- You meet the eligibility requirements stated above; **and**
- You complete the Fund's election form to apply for this benefit and submit the form to the Fund prior to the termination of your coverage.

When Coverage Ends

Eligibility to participate ends on the earlier of:

- The last day of the month when you do not pay the premium when required;
- The last day of the following month in which your status with your local union is suspended;
- The date your pension benefit is suspended for any reason;
- The date you and/or your spouse become eligible under another group health plan;
- The date you or your eligible dependent(s) become entitled to Medicare; or 36 months whichever occurs first
- The date the Plan terminates.

If you discontinue the Retiree Health Benefits Plan, you cannot resume coverage under the Plan unless you return to covered employment and meet the eligibility requirements again when you re-retire.

See the Schedule of Medical Benefits for the Retiree Health Benefits Plan on pages 102-103.

Eligibility for Widow(ers) and Dependent Children of Deceased Retirees

If you were receiving a pension benefit from the New England Carpenters Health Benefits Fund or the United Brotherhood of Carpenters Labor Management Pension Fund at the time of your death, your widow(er) and eligible dependent children may continue coverage under the Retiree Health Benefits Plan on a self-pay basis for the same amount. If a dependent child reaches the age limit, the dependent is eligible to buy into Plan II under COBRA for 36 months.

COORDINATION OF BENEFITS/SUBROGATION

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

Coordination of Benefits / Subrogation

Members of a family are often covered under more than one group health plan, which could result in duplication of health coverage. To avoid this, the health care benefits provided by this Fund are coordinated with similar benefits payable under other plans.

- You must report any duplicate group health coverage for yourself and/or your dependents on any claim you submit to the Fund Office.
- Benefits under this Fund are coordinated with HMO, PPO, Medicare or other group health care coverage.
- Benefits under this Fund do not coordinate with another plan's prescription drug benefits.

Under the Coordination of Benefits provision, if you are covered under any other group health plan, the total payment you receive from all programs may not be more than 100% of the "allowable expenses." Allowable expenses are the necessary and reasonable expenses for treatment or supplies covered by the primary plan that you are covered under.

METHODS OF COORDINATION

The plan under which benefits are payable first is the primary plan. All other plans are called secondary plans. The following rules determine which plan's benefits are payable first and follow the National Association of Insurance Commissioner's Model Rules:

- A plan that does not contain a Coordination of Benefits provision is always primary.
- A plan that covers you as a participant is primary.
- If you are covered as a participant under two plans, the plan that has covered you for a longer period is primary.
- A plan that covers you as an participant pays before a plan that covers you as a laid-off participant or retiree.

Dependent Child Covered Under More Than One Plan

If the parents of a child are married or are living together, then the plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second. If the parents are not living together but a court decree awards joint custody to both parents without specifying that one parent has the responsibility to provide health care coverage for the child, this rule also applies.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are divorced, separated or not living together (regardless of whether they were ever married), and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

1. The plan of the custodial parent pays first; and
2. The plan of the spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last.

Coordination of Benefits with Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Similar Organizations

If you or your dependents are covered by an HMO, a PPO, or a similar health care organization and that group health plan is primary, you must utilize all health care alternatives available to you through the other provider(s) before this Fund will honor any claim for benefits. Also, if a participant or his/her dependents violates the provisions of the HMO, such as neglecting to use that plan's facilities or following managed care or prior authorization provisions, no benefits will be payable under this Plan.

COORDINATION OF BENEFITS WITH MEDICARE

When you reach age 65 or if you become disabled, you are eligible for hospital insurance benefits ("Part A") and supplementary medical insurance ("Part B") under Medicare. The chart below illustrates how your benefits are paid at that time.

TYPE OF PLAN PARTICIPANT	PRIMARY PLAN	SECONDARY PLAN
Retiree or dependent who is Medicare-eligible (and unemployed) unless you are covered under work hours, then it is reversed	Medicare	This Fund
Retiree who is not Medicare-eligible	This Fund	N/A
Participant with worked hours and/or dependent who is Medicare-eligible	This Fund	Medicare
Disabled participant awarded SSDI	Medicare	This Fund

Coverage for Disabled Participants or Participants' Disabled Dependents with End-Stage Renal Disease (ESRD)

If you are actively employed and you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

- The month in which Medicare ESRD coverage begins; or
- The first month in which the individual receives a kidney transplant.

Then, starting with the 31st of the month, Medicare pays first and this Plan pays second.

ENROLLING IN MEDICARE

You must enroll in Medicare Parts A and B as soon as you are eligible—three months before your 65th birthday or in certain cases when you become disabled—in order to avoid a gap in coverage.

To Enroll in Medicare:

- Visit your local Social Security Office;
- Call 800-MEDICARE (800-633-4227); or
- Go to the Medicare website at www.medicare.gov.

TRICARE MILITARY COVERAGE

If you and/or your family are covered by both this Fund and TRICARE, the coordination of benefits depends on whether you are called up to active duty for more than 30 days and whether your family continues coverage under this Plan. If you are on active duty for more than 30 days, TRICARE will be primary and this Plan will be secondary. However, if your eligible dependents elect COBRA and continue benefits under this Plan, this Plan would be primary and TRICARE would be secondary for them.

MOTOR VEHICLE NO-FAULT COVERAGE REQUIRED BY LAW

If you are covered by both this Fund and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Fund pays second.

WORKERS' COMPENSATION

This Fund does NOT provide benefits if the medical expenses are covered by Workers' Compensation or Occupational Disease Law.

Reimbursement and Subrogation

You or one of your eligible dependents may incur medical expenses in a situation where a third party—for example, Workers' Compensation or an auto insurance carrier—may be held responsible for their payment. In this case, the Fund has all rights of recovery that you or your dependents would have, including the right to bring suit in your name.

You must cooperate with the Fund to secure the recovery of the payment, and you must do nothing before or after payment by the Fund to prejudice its rights. If you recover from the third party or its insurer, you must reimburse the Fund for expenses that it has paid. When you and/or your eligible dependents incur medical expenses where a third party may be held responsible for payment you must:

- Notify the Fund Office, and
- Execute a Subrogation and Reimbursement Agreement.

The Subrogation and Reimbursement Agreement must be executed by you and/or your covered dependent, and received by the Fund Office within 90 days from the date of the incident and in no event later than 12 months from the date of the incident. The amount of reimbursement due to the Fund is based on the following schedule:

TOTAL RECOVERY	FUND'S SHARE OF RECOVERY
1. Equal or less than benefits	50% of the benefits
2. Greater than one times, but less than two times benefits	65% of the benefits
3. Greater than two, but less than three times benefits	75% of the benefits
4. Greater than three, but less than four times benefits	85% of the benefits
5. Greater than four times	100% of the benefits

In no event shall the Fund's share of recovery be greater than 50% of the total recovery following the deduction of the participant's reasonable attorney's fees (not to exceed 33% of the total recovery).

Before paying benefits for expenses that may be the responsibility of a third party, you and/or your dependents will be required to sign an agreement affirming the Fund's lien rights and the obligation of you and your dependents to reimburse the Fund from the proceeds of any recovery. The Fund may withhold payments on any claim until a reimbursement agreement is executed. The Fund's lien rights and your obligation to reimburse the Fund, however, are not dependent on whether you sign a reimbursement agreement. By accepting the payment of benefits, you and your dependents agree to the Fund's subrogation and reimbursement policies.

You and/or your eligible dependent must execute the reimbursement agreement and submit it for receipt by the Fund Office within 90 days of the date of the accident or injury. If it is not reasonably possible to submit the executed reimbursement agreement within 90 days, it must be received by the Fund Office as soon as reasonably possible but in no event later than one year from the date of the accident or injury. If you fail to comply with this obligation to sign and submit the reimbursement agreement within the deadline, the Fund will deny claims relating to the accident or injury.

If you receive payment from a third party under any circumstances, the Fund has a lien on that payment and you must reimburse the Fund in accordance with the schedule above from the proceeds. Reimbursement is mandatory regardless of whether:

- a claim was ever asserted for the amount received.
- the proceeds were paid by way of settlement, judgment, arbitration award or otherwise.
- you feel that you were "made whole" for your losses by recovery.
- the amount received is characterized as attributable to medical expenses, lost income, pain and suffering, loss of consortium or otherwise.
- part of the recovery is received by family participants other than the primary injured party such as on a loss of consortium; in such cases the "total recover" is the combined recoveries of all such family members.

The Fund has an equitable interest and lien in the amount that you receive, and you, your dependents, and those acting on your behalf, including your attorneys, are under obligation to keep the amounts received in a separate segregated account until your obligations to the Fund are satisfied and all disputes concerning those obligations are settled. The Fund may enforce this obligation by seeking equitable relief in court against you and your representatives, including your attorneys.

In the event that the participant or dependent submits additional claims for benefits following settlement of a liability claim and reimbursement to the Fund, the Fund will withhold future benefits, but only to the extent that the additional benefits would have been reimbursable under the formula had the settlement occurred later.

If you or your dependents or your agents or representatives, including your attorneys, do not reimburse the Fund after receiving payment from a third party or otherwise fail to comply with the obligations set forth here, the Fund may institute legal and/or equitable action in court. In such event, you will be responsible for all the costs and attorney's fees associated with that court proceeding, and will be obligated to pay all interest on all amounts owed from the date they were due. If you or a dependent fails to reimburse the Fund, or fails to reimburse the Fund for litigation and costs and attorneys' fees in accordance with this section, the Fund may withhold payment of future benefits from you as well as all of your dependents up to the amounts due plus interest.

New Procedure effective June 1, 2018 - For claims processed on or after June 1, 2018 that may have a third party liability, the Fund will pay these claims and then Blue Cross Blue Shield of Massachusetts, on behalf of the Fund, will request information via US Mail from the covered person regarding possible third party liability. In the event the covered person responds to the inquiry and at the Fund's discretion determines that there is a likelihood of third party liability, the Fund will require the covered person to sign the Reimbursement and Lien Agreement as a condition for payment of benefits in the future. If the covered person does not sign the Agreement, the Fund will retract payments that had previously been paid to providers. This new process will be used only when the third party liability is uncertain. Otherwise the process outlined in the paragraphs above will continue when the third party liability is clear, such as, but not limited to, Motor Vehicle Accidents and work related injuries.

CONTINUING YOUR COVERAGE (COBRA)

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

About Continuing Your Coverage

Generally, you are eligible to continue your health care coverage under a law known as COBRA. COBRA is discussed in detail on the following pages of this section.

The Fund also provides continued coverage in several circumstances where the individual otherwise would lose coverage and be entitled to COBRA—such as an extension of coverage due to disability or death of a participant. See the Life Events section for more information.

Here are important things to know about COBRA:

- You and your dependents may continue certain medical benefits under COBRA if your coverage ends due to a "qualifying event," explained on page 62.
- Your children are eligible to continue coverage under COBRA when they no longer satisfy the Fund's definition of eligible dependent because of age.
- To keep your coverage under COBRA, you must make monthly payments to the Fund Office on time. You are fully responsible for the payment of your benefits through COBRA.

About the Marketplace

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If your coverage under the New England Carpenters Health Benefits Fund ends due to a "qualifying event" (see below), you and/or your covered dependents may be eligible to continue your health care coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

By making monthly payments, you and/or your dependents may continue the same medical, dental, vision and prescription drug coverage that you had before your coverage ended. Your coverage can last for up to 18, 29 or 36 months, depending on the qualifying event that resulted in your loss of coverage.

COBRA Continuation Coverage

QUALIFYING EVENTS

To be eligible to elect COBRA Continuation Coverage, you (as the participant) and/or your dependent(s) must lose coverage due to any one of the qualifying events, which are listed in the first column in the table below. The last column indicates how individuals find out that they're eligible for Continuation Coverage, which are explained below.

QUALIFYING EVENT	WHO MAY PURCHASE	ELIGIBILITY	NOTIFICATION REQUIREMENTS
Participant terminated for other than gross misconduct (including retirement)	Participant, spouse and/or dependent children	18 months	Fund Office will advise eligible participants
Participant experiences reduction in hours worked (making participant ineligible for coverage or the same coverage he or she currently has under the Plan)	Participant, spouse and/or dependent children	18 months	Fund Office will advise eligible participants
Participant becomes entitled to Medicare	Spouse and/or dependent children	36 months	Fund Office will advise participants when they reach 65. If they become eligible before 65, they must advise the Fund Office
Participant becomes eligible for disability through Social Security	Participant, spouse and/or children	11 months in addition to the 18 months	Participant must advise Fund Office
Death of participant	Spouse and/or dependent children	36 months	The family must notify Fund Office
Participant is divorced	Spouse and/or dependent children	36 months minus the number of months covered since the divorce	Participant or spouse must advise Fund Office so notification can occur
Child ceases to be an eligible dependent under Plan definition	Dependent child	36 months	Participant or dependent child must advise Fund Office so notification can occur

NOTIFY THE FUND OFFICE
You or a family member should notify the Fund Office when any qualifying event occurs to avoid confusion over the status of your health care in the event that your employer does not provide prompt or correct information.

WHO MAY ELECT COBRA?

Under the law, only "qualified beneficiaries" are entitled to elect COBRA Continuation Coverage. A qualified beneficiary is any participant, his or her spouse or dependent who was covered by the New England Carpenters Health Benefits Fund when a Qualifying Event occurs. A child who becomes a dependent child by birth, adoption or placement for adoption with the participant during a period of COBRA Continuation Coverage is also a qualified beneficiary. However, a spouse you acquire during a period of COBRA continuation coverage is not considered a qualified beneficiary—although he or she may be covered under your COBRA coverage.

One or more of your family members may elect COBRA even if you do not. Additionally, one family member may elect COBRA for all qualified beneficiaries. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the qualifying event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her. A participant may elect but may NOT waive COBRA coverage on behalf of a spouse.

How to Elect COBRA Continuation Coverage

- In order to elect COBRA Continuation Coverage, the Fund Office must be notified when you experience a qualifying event. You must notify the Fund Office within 60 days from the date that the qualifying event occurs, or the date that you would lose coverage under the Fund because of the qualifying event, whichever is later. See the following Notification Procedures.
- When the Fund receives notice of the qualifying event, he or she will mail you an election form, information about COBRA and the date on which your coverage will end. Under the law, you and/or your covered dependents have 60 days from the later of the date:
- You would have lost coverage because of the qualifying event; or
- You and/or your covered dependents received the election form and COBRA information.

If you and/or any of your covered dependents do not elect COBRA within 60 days of the qualifying event (or, if later, within 63 days from the mailing date), you and/or your covered dependents will not have any group health coverage from this Fund after your coverage ends.

WHAT YOU NEED TO DO

If you lose coverage due to a Qualifying Event:

- **Inform the Fund Office of the qualifying event and request a COBRA election form.**
- **Complete and mail back the election form within 63 days of the date of the mailing, or 60 days of the date the qualifying event occurred, whichever is later.**
- **Make your first payment to the Fund Office within 45 days from the date the Fund Office receives your COBRA election form.**

COBRA NOTIFICATION PROCEDURES

As a covered participant or qualified beneficiary, you are responsible for providing the Fund with timely notice of certain qualifying events. You must provide the Fund notice of the following qualifying events:

- The divorce of a covered participant from his or her spouse.
- A beneficiary ceasing to be covered under the Plan as a dependent child of a participant.
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include a participant's death, entitlement to Medicare, divorce or child losing dependent status.

In addition to these qualifying events, there are two other situations when a covered participant or qualified beneficiary is responsible for providing the Fund with notice within the timeframe noted in this section:

- When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund is notified of any of these five occurrences listed above. Failure to provide this notice within the form and timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

How Should a Notice Be Provided?

In order to provide the Fund notice of any of these five situations you must complete and sign the Fund's "COBRA Notice Form for Covered Employees and Qualified Beneficiaries." You can obtain a copy of the form by calling the Fund Office at 800-344-1515.

Alternatively, you may send a letter to the Fund containing the following information: your name, for which of the five events listed above you are providing notice, the date of the event, and the date in which the participant and/or beneficiary will lose coverage.

To Whom Should the Notice Be Sent?

Notice should be sent to the Fund at the following address:

The New England Carpenters
Health Benefits Fund
350 Fordham Road
Wilmington, MA 01887
Phone: 800-344-1515
Fax: 978-752-1148

When Should the Notice Be Sent?

If you are providing notice due to a divorce, a dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than 60 days after the later of (1) the date upon which coverage would be lost under the Plan as a result of the qualifying event (2) the date of the qualifying event or (3) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Fund.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than the end of the first 18 months of continuation coverage. If you are providing notice of a Social Security Administration determination that you are no longer disabled, notice must be sent no later than 30 days after the later of (1) the date of the determination by the Social Security Administration that you are no longer disabled or (2) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Fund Administrator.

Who Can Provide a Notice?

Notice may be provided by the covered participant, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered participant or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if a participant and his or her spouse and child are all covered by the Plan, and the child ceases to become a dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

Where you or your dependents have provided notice to the Fund of a divorce, a beneficiary ceasing to be covered under the Plan as a dependent or a second qualifying event, but are not entitled to COBRA, the Fund will send you a written notice stating the reason why you are not eligible for COBRA.

PAYING FOR COBRA CONTINUATION COVERAGE

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your dependents become eligible for this coverage, the Fund will notify you of the COBRA premium amounts that you must pay.

Your COBRA premiums may be as high as 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Continuation Coverage for Disabled Participants.")

You must send the first COBRA payment to the Fund Office within 45 days from the date on which the Fund Office receives your COBRA election form, as determined by postage cancellation. You must make payments so that coverage is continuous—there can be no lapse in coverage. If you choose COBRA within the election period but after the date on which your eligibility ended, you must pay the required COBRA premiums retroactively to cover the elapsed period.

Late COBRA Payments

Your monthly payments are due on the first day of each month. You will have 30 days in which to pay. Payments should be mailed to the Fund Office. If you do not make payment by the end of the 30 days, your coverage will be canceled retroactively to the last day of the previous month and you will lose your right to continuation coverage.

CERTIFICATE OF CREDITABLE COVERAGE

When your coverage through the Fund ends, the Fund Office will mail you and/or your dependents a Certificate of Creditable Coverage that indicates the period of time that you were covered under the New England Carpenters Health Benefits Fund.

COBRA CONTINUATION COVERAGE FOR DISABLED PARTICIPANTS

If you are covered under COBRA for 18 months, and within the first 60 days of coverage you (or your covered dependent) become disabled, you (and your Qualified Beneficiaries who elected COBRA) may be eligible to continue your COBRA coverage for an additional 11 months, for a total of 29 months.

To be eligible, the Social Security Administration must make a formal determination that you (or your dependent) were disabled effective within the initial 60-day period of the start of your COBRA coverage and therefore entitled to Social Security Disability income benefits. You (or your dependent) must notify the Fund Office of the Social Security determination of disability by the end of the 18-month initial COBRA period if you wish to continue with the 11-month extension.

If you are eligible for the 11-month extension, your COBRA premiums may be as high as 150% of the regular premiums for the additional 11 months of coverage. This extended period of COBRA coverage will end on the earlier of:

- The last day of the month that occurs 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
- The end of the 29 months' COBRA Continuation Coverage;
- The date the disabled person becomes entitled to Medicare. If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Fund Office within 30 days of:
    - The date that you receive a final Social Security determination that you and/or your dependent(s) are no longer disabled; or
    - The date that the disabled person becomes entitled to Medicare.

MULTIPLE QUALIFYING EVENTS WHILE COVERED UNDER COBRA

The maximum period of coverage under COBRA is 36 months, even if you experience another Qualifying Event while you're already covered under COBRA. If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected spouse or dependent may extend coverage for another 18 months in the event of your death or if:

- You get divorced;
- You become entitled to Medicare; or
- Your child is no longer a dependent under the Fund's definition.

For example, you stop working (the first COBRA-Qualifying Event), and you enroll yourself and your dependents for COBRA Continuation Coverage for 18 months. Three months after your COBRA Continuation Coverage begins, your child turns 26 and no longer qualifies as a dependent child under the Fund's definition. Your child then can continue COBRA coverage separately for an additional 33 months, for a total of 36 months' COBRA Continuation Coverage.

You, as the participant, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to additional COBRA Continuation Coverage on account of disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and you may not extend your coverage.

COVERAGE FOR YOUR DEPENDENTS IF YOU'RE ENROLLED IN MEDICARE

If you are entitled to or enrolled in Medicare and you have a termination of employment or reduction in hours, your eligible dependents would be entitled to COBRA for a period of 18 months (29 months if the 11-month Social Security Disability extension applies) from the date of your termination of employment or reduction in hours or 36 months from the date you became entitled to Medicare.

SPECIAL COBRA ENROLLMENT RIGHTS

If you marry, have a newborn child, adopt a child or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage. You must enroll your new dependent within 31 days of the marriage, birth, adoption or placement for adoption, with proper documentation.

In addition, if you are enrolled for COBRA Continuation Coverage and your spouse or dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 31 days after the termination of the other coverage.

To be eligible for this special enrollment right, your spouse or dependent child must have been eligible for coverage under the terms of the Plan but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage, with proper documentation.

CONFIRMATION OF COVERAGE TO HEALTH CARE PROVIDERS

Under certain circumstances, federal rules require the Fund to inform your physician and health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the physician or provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA coverage, or you have elected COBRA coverage but have not yet paid for it.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- You do not make all required payments on time;
- The person receiving the coverage becomes covered by another group health plan;
- The person receiving the coverage becomes entitled to Medicare;
- The Plan terminates its group health plan and no longer provides group health insurance coverage to its participants; or
- The employer that employed you prior to the qualifying event has stopped contributing to the Plan; and
- The employer establishes one or more group health plans covering a significant number of the employer's employees formerly covered under this Plan; or
- The employer starts contributing to another multiemployer plan that is a group health plan.

If continuation coverage is terminated before the end of the maximum coverage period, the Fund will send you a written notice as soon as practicable following the Fund's determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

If you have questions about COBRA Continuation Coverage, contact the Fund Office at 800-344-1515.

Additional COBRA Election Period and Tax Credit in Cases of Eligibility for Benefits Under the Trade Act of 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Act Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the United States Department of Labor Employment and Training Administration, Office of Trade Adjustment Assistance at 888-365-6822. More information about the Trade Act is also available at https://www.doleta.gov/Tradeact/. The Fund may also be able to assist you with your questions.

Keep the Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund informed of any changes in the addresses of your family participants. You should also keep a copy, for your records, of any notices that you send to the Fund. If you need further information about COBRA, ACA, HIPAA, or ERISA, visit the Employee Benefits Security Administration's (EBSA's) website at dol.gov/ebsa. Or you may contact EBSA electronically at askebsa.dol.gov or call toll free 866-444-3272.

GENERAL EXCLUSIONS

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

General Exclusions

The following is a partial list of plan exclusions. You may call the Fund Office to request specific information as to whether or not a service or supply is a covered expense.

The Plan excludes expenses or charges:

- For services or supplies not recommended by a physician or surgeon or not medically necessary in treating the injury or illness;
- That are in excess of the Plan's allowed amount;
- For services or supplies rendered or provided outside the United States, except for treatment for a medical emergency or medical necessity as defined in the Glossary of this document;
- For medical care or treatment and services or supplies for charges that are made by a nursing home, rest home, convalescent home or similar establishment;
- For services or supplies that are:
  - Not provided in accordance with generally accepted professional medical standards; or
  - For experimental or investigational treatment;
  - That are in excess of the allowed amount;
- For custodial care, when not provided in your home at the direction of a hospice care organization;
- That result from cosmetic or reconstructive surgery except:
  - In the case of a mastectomy patient;
  - When surgery is performed on an eligible dependent child because of a congenital disease or anomaly that has resulted in a functional defect as determined by his or her attending physician or surgeon; or
  - In the case of an accidental bodily injury;
- In connection with dental work, X-rays or surgery (unless part of the dental benefits for Plan I participants), except expenses for services that are required for correction of damage caused by an accidental injury to a sound and natural tooth sustained by an eligible person, or for tumors or cysts of an eligible person;
- For temporomandibular joint disorders (TMJ), which are excluded for appliances and services, supplies or procedures to increase the height of teeth (increase vertical dimension or restore occlusion) except for (1) disorders caused by or resulting in a specific medical condition, such as degenerative arthritis and jaw fractures or dislocations. The medical condition must be proven to exist by means of diagnostic X-ray tests or other generally accepted diagnostic procedures; (2) and a mandibular orthopedic repositioning appliance (MORA);
- Early intervention services;
- Made by a Veterans' Administration Hospital or by a physician employed by a Veterans' Administration Hospital if the disability is service-related, except as mandated by law;
- That the participant is not legally required to pay or that is for medical care furnished without charge, paid for or reimbursable by or through a government agency or county, except where specifically prohibited by applicable statute;
- For special home construction to accommodate a disabled person;

- For medical or surgical treatment of obesity, including but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof. (Exception: covered when deemed medically necessary and when for obesity related services covered under the preventive care benefit);
- For medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements, other food or nutritional supplements, or nutritional counseling, except in conjunction with medically necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by physicians to determine normal body weight;
- For memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs;
- For sterilization reversals;
- For failure to appear for an appointment as scheduled, for completion of claim forms, attorneys' reports or late stay charges;
- For injury, illness or dental treatment for which an eligible person has received or is entitled to receive benefits under a Workers' Compensation or Occupational Disease Law or that arises out of or in the course of any occupation or employment;
- For any loss, expense or charge resulting from an eligible person's participation in the commission of a felony;
- For any loss, expense or charge resulting from an act of declared or undeclared war, armed aggression or act of terrorism;
- For any loss, expense or charge incurred while an eligible person is on active duty or in training in the Armed Forces, National Guard or Reserves of any state or country;
- For supplies or equipment for personal hygiene, comfort or convenience such as air conditioning, humidifier, physical fitness and exercise equipment, tanning bed or water bed;
- For court-ordered or random drug testing;
- For services rendered when not an eligible participant;
- Claims not received in the Fund Office within 12 months from date of service;
- All expenses for services and/or products related to assisted reproduction, maternity care, and delivery provided to a Plan participant or dependent who is acting as a surrogate for another person;
- All expenses for services and/or products related to assisted reproduction, maternity care, and delivery provided to a third person, not covered by the Plan, and acting as a surrogate for a Plan participant or dependent;
- Related to a child resulting from a surrogate pregnancy;
- Related to the care and treatment of adverse complications to the surrogate and/or the surrogate child resulting from the pregnancy and delivery:
    - If a Plan participant or dependent who receives any benefits from the Fund for any services or products to which she is not entitled under the terms of these exclusions relating to surrogacy, regardless of whether the surrogate is the Plan participant or a dependent, the Board of Trustees may take such action as it, in its full discretion, deems appropriate.
    - Such action can include, but not be limited to, retraction of any benefits paid, recoupment of any benefits paid by denial of future benefits to the Plan participant and all dependents, recovery by any other legal means of the benefits paid, and permanent rescission of all future coverage by the Fund of the Plan participant and all dependents.

Contact the Fund Office at 800-344-1515 for specific information about whether or not a service or supply is a covered expense.

REGULATORY INFORMATION

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

Regulatory Information: Filing Your Claims

A **claim for benefits** is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form unless your hospital, doctor or other health care provider uses a standard billing form and files it directly with the Fund on your behalf.

General inquiries about the Plan's provisions that are unrelated to any specific benefit claim or requests to add or improve the Plan's benefits will not be treated as a claim for benefits. In addition, a request for pre-approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

All of the following information must be completed on the claim form that you get from your provider(s) in order for your request for benefits to be a claim, and for the Fund Office to be able to decide your claim.

- Participant's name and Social Security number
- Participant's address
- Participant's date of birth
- Participant's marital status
- Coordination of benefits information
- Spouse's name and Social Security number (if applicable)
- Spouse's date of birth and employment status (if applicable)
- Name, address and telephone number for spouse's employer
- Patient name and address (if different from Participant)
- Patient's relationship to insured
- Patient's date of birth
- Patient's sex
- Was condition related to patient's employment, or accident
- Date(s) of service
- Date patient able to return to work
- Date of total/partial disability
- Name of referring physician
- Hospitalization dates, if applicable
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition or later, as maintained and distributed by the American Medical Association)
- ICD-10 (the diagnosis code found in the International Classification of Diseases, 9th Edition or later, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge, amount paid and balance due
- Signature of service provider
- Federal taxpayer identification number (TIN) of the provider
- Provider billing name and address

Most accepted standard claim forms contain an assignment of benefits agreement, in the event you wish to assign your hospital or surgical benefits

directly to the hospital or doctor. Upon receipt of the assignment agreement, the Fund Office will directly pay these benefits to your health care provider. Please remember that any BCBSMA participating network provider will be paid directly by the Fund. When you use a participating provider, and follow prior authorization requirements, you are only responsible for the copayment amount at the time of the service and any coinsurance and deductible, depending on the benefit.

WHEN CLAIMS MUST BE FILED

Claims should be filed within **90 days** from the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and **in no event later than one year** from the date the charges were incurred. When you and/or your eligible dependents incur charges in circumstances where a third party may be liable, you and/or your eligible dependent must:

- Notify the Fund Office.
- Execute and return a reimbursement agreement within 90 days of the accident or injury. (See section of this book on Reimbursement and Subrogation).

POST-SERVICE CLAIMS

A **Post-Service Claim** for benefits (as defined on page 75) is considered received by the Fund as follows:

For Medical, Hospital, and Accident and Sickness (Disability) Claims

On the first business day when the claim is received by U.S. mail or hand-delivered to the Fund Office at the following address:

Blue Cross Blue Shield of Massachusetts
P O Box 986030
Boston, MA 02298
Telephone: 1.800.782.3675

The claim is submitted electronically by your provider and received by Blue Cross Blue Shield of MA

For Dental Claims

On the first business day when the claim is received by U.S. mail by Delta Dental at the following address:

Delta Dental Plan of Massachusetts
P.O. Box 9695
Boston, MA 02114

The claim is submitted electronically by your provider and received by Delta Dental.

For Vision Claims

On the first business day when the claim is received by U.S. mail by Davis Vision at the following address:

Davis Vision
P. O. Box 1525
Latham, NY 12110
800-999-5431

The claim is submitted electronically by your provider and received by Davis Vision.

URGENT, PRE-SERVICE AND CONCURRENT CLAIMS

Urgent, Pre-Service and Concurrent Care Claims (as defined on pages 74-75) are generally requests for prior authorization of a treatment or hospital stay. An urgent, pre-service or concurrent claim is considered received when a telephone call is made by you or your provider to BCBSMA at 800-944-9401, or your provider electronically contacts BCBSMA requesting prior authorization.

PRESCRIPTION DRUG CLAIMS

Express Scripts provides prior authorizations for specified drugs. For a complete listing of these drugs, call 800-939-3750. When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

Claims Communications

All claims communications will be addressed to and sent to the participant unless the patient makes a written request to the Health Benefits Fund Office specifically requesting that any claims communications be sent under the patient's name to a different address.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have designated an individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person 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 the special authorization form.

COMPREHENSIVE MEDICAL BENEFITS CLAIMS

The claims procedures for comprehensive medical benefits will vary depending on whether your claim is for a **Pre-Service Claim**, an **Urgent Care Claim,** a **Concurrent Care Claim,** or a **Post-Service Claim.** For each of these types of claims, a "denial" or "denied claim" is defined as:

1. A denial, reduction or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any such occurrence that is based on:
   a. A determination of an individual's eligibility to participate in a Plan, or
   a. A determination that a benefit is not a covered benefit.
2. A reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, or
3. Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions, or it is the result of fraud or intentional misrepresentation.

Read each section carefully to determine which procedure is applicable to your request for benefits:

PRE-SERVICE AND URGENT CARE CLAIMS

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, prior approval of services is required for all hospital admissions, complementary medicine, home health care, hospice care, certain prescription drugs, inpatient and partial day mental health and substance abuse treatment.

BCBSMA administers Pre-Service, Urgent and Concurrent Care Claims. For properly filed **Pre-Service Claims,** you and/or your doctor will be notified of a decision within ***15 days*** from receipt of the claim unless additional time is needed. The time for response may be extended up to an additional *15 days* if necessary due to matters beyond the control of BCBSMA. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because BCBSMA needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have ***45 days*** from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either ***45 days*** or the date you respond to the request (whichever is earlier). BCBSMA then has ***15 days*** to make a decision on the **Pre-Service Claim** and notify you of the determination.

If you or your doctor **improperly file a Pre-Service Claim,** BCBSMA will notify you as soon as possible but not later than ***5 days*** after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed **Pre-Service Claim** if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

An **Urgent Care Claim** is any claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

1. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
2. in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of your medical condition determines is an **Urgent Care Claim** within the meaning described above, will be treated as an **Urgent Care Claim.** Absent a determination by that physician, whether your claim is an **Urgent Care Claim** will be determined by BCBSMA applying the judgment of a prudent layperson who possesses average knowledge of health and medicine.

If you are requesting prior authorization of an **Urgent Care Claim,** the time deadlines are different than those that apply to Pre-Service Claims. BCBSMA will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical condition, but not later than ***72 hours*** after receipt of the claim by BCBSMA. The determination will also be confirmed in writing.

If an **Urgent Care Claim** is received without sufficient information to determine whether or to what extent benefits are covered or payable, BCBSMA will notify you and/or your doctor as soon as possible, but not later than ***24 hours*** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within ***48 hours*** of receiving notice. If the information is not provided within that time, your claim will be denied. Unless the claim is refiled properly, it will not constitute a claim.

Notice of the decision will be provided no later than ***48 hours*** after BCBSMA receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

CONCURRENT CARE CLAIMS

A **Concurrent Claim** is a claim for additional treatment or hospital days or 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 this type of claim would be an inpatient hospital stay originally approved for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made at the same time or "concurrently" with the provision of treatment.

Reconsideration of a benefit with respect to a **Concurrent Care Claim** that involves the ***termination or reduction*** of a previously approved benefit (other than by plan amendment or termination) will be made by BCBSMA as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to ***extend*** approved urgent care treatment will be acted upon by BCBSMA within ***24 hours*** of receipt of the claim, provided the claim is received at least ***24 hours*** prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

POST-SERVICE CLAIMS

The following procedure applies to **Post-Service Claims.** A **Post-Service Claim** is a claim that is not a **Pre-Service, Urgent Care, or Concurrent Care Claim** (for example, a claim submitted for payment after health services and treatment have been obtained).

Your provider should submit all claims on your behalf to BCBSMA. If you experience a problem submitting a claim, call the Fund Office.

You do not have to submit an additional claim form with your bills or statements, if you have filed the annual health claim during the calendar year. Mail any further bills or statements for any medical or hospital services covered by the Plan to the address shown on your ID card as soon as you receive them. Your provider may also submit bills on your behalf.

Ordinarily, you will be notified of the decision on your **Post-Service Claim** within ***30 days*** from the Plan's receipt of the claim. This period may be extended once by the Plan for up to ***15 days*** if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information 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 within that time, your claim is deemed denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either ***45 days*** or until the date you respond to the request (whichever is earlier). The Plan then has ***15 days*** to make a decision on a **Post-Service Claim** and notify you of the determination.

NOTICE OF DENIED MEDICAL CLAIMS

You will be provided with a written notice of a denial of a medical claim, whether denied in whole or in part, that will include:

- Information sufficient to identify the claim, including the date of the service, the health care provider, the claim amount (if applicable);
- A statement that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided to you. However, this request will not be treated as a request for a voluntary appeal or external review;
- A statement that you are entitled to receive, upon request and free of charge, access to copies of documents relevant to your claim;
- A statement with the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;

- Reference to the specific Plan provision(s) on which the determination is based;
- If relevant, a description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the Plan's external review process, along with the applicable time limits and information on how to initiate an appeal;
- A statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal;
- If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational , or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- The availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes.

DISABILITY CLAIMS (WEEKLY ACCIDENT AND SICKNESS BENEFIT)

You must file a claim for Weekly Accident and Sickness Benefits with the Fund Office no later than 90 days after the date your disability began.

For **Disability Claims,** the Plan will make a decision on the claim and notify you of the decision within ***45 days***. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within ***30 days*** of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional ***30 days,*** provided the Plan administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information 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 within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either ***45 days*** or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim, or the need for an extension, within ***30 days.***

NOTICE OF A DENIED CLAIM

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect 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 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.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment

was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

APPEAL PROCESS FOR DENIED CLAIMS

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office and must be received within ***180 days*** after you receive a notice of denial. Appeals involving **Urgent Care Claims** may be made by calling the Fund at 800-344-1515 **for Urgent and Concurrent Care Claim appeals only.** There is a second level of appeal for Post- Service and Disability claims, and appeals to the second level concerning those claims must be received by the Fund Office within ***60 days*** of the date of the decision at the first level of appeal. The appeal process works as follows.

Urgent Care, Pre-Service and Concurrent Care Claim Appeals

For Urgent, Pre-Service and Concurrent Claim Appeals, there is one level of appeal. Appeals should be made in writing to the Fund Office. A subcommittee of the Board of Trustees will review Urgent Care, Pre-Service and Concurrent Care Claim appeals. In certain circumstances such as Urgent Care Claim appeals where medical conditions exist that require an expedited review process, appeals may be made via telephone.

POST-SERVICE AND DISABILITY CLAIM APPEALS

For Post-Service and Disability Claim appeals, there is a two-level appeal process. Appeals at both levels must be in writing and must be submitted to the Fund Office. The first level of appeal will consist of a review by the Fund. First level appeals must be received by the Fund Office within ***180 days*** after you receive the Fund's notice of its denial of your claim. If the Fund denies your first level appeal, you have the right to a second level appeal to the full Board of Trustees. Second level appeals must be received by the Fund Office within ***60 days*** of the date of the Fund's decision at the first level.

Information to Which You Are Entitled

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon in making the decision); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of Plan policy regarding the denied treatment or service. In addition, you have the right to any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale that the Plan relies on in making its decision about your claim. This new or additional information will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of the appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. The information described in this section will be provided free of charge.

Upon request, you will be provided with the identification of medical or vocational experts, if any, who gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim or the previous appeal. The reviewer will not give deference to the previous adverse benefit determinations. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

TIMING OF NOTICE OF DECISION ON APPEAL

- **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Fund Office.
- **Urgent Care Claims:** You will be notified of a decision on your appeal, either orally or in writing (or both) within 72 hours of receipt of the appeal by the Fund Office.
- **Post-Service Claims:** For first level appeals, a decision will be made on the appeal within 30 days of receipt of the appeal by the Fund. For second level appeals, decisions will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, the Fund Office will give you written notice of the decision as soon as possible, but no later than 5 days after the decision has been reached.
- **Disability Claims:** For first level disability claim appeals a decision will be made by the Fund within 45 days of receipt of the appeal at the Fund Office. If the Fund determines that special circumstances require an extension of time, you will receive a written notice of the extension before the end of the 45-day period. The notice will include the reasons required for the extension and the approximate date the Plan expects to make a decision. For second level appeals, decisions will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, the Fund Office will give you written notice of the decision as soon as possible, but no later than 5 days after the decision has been reached.
- **Concurrent Care Claims:** Appeals of concurrent claims involving a termination or reduction of benefits of previously approved care shall be completed before the termination or reduction. The claimant shall be given notice sufficiently in advance of the termination or reduction to allow the claimant to appeal before the benefit is terminated or reduced. Appeals of concurrent claims involving an extension of care shall be conducted within the timeframe for urgent, pre-service or post-service appeals described above, depending on which category applies to the appeal.

NOTICE OF DECISION ON REVIEW

The decision on any review of your claim will be given to you in writing. The notice of a denial of an appeal will include:

1. Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount (if applicable);
2. A statement that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided to you. However, a request for this information will not be treated as a request for a voluntary appeal or external review;
3. A statement that you are entitled to receive, upon request and free of charge, access to copies of documents relevant to your claim;
4. The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
5. Reference to the specific Plan provision(s) on which the determination is based;
6. If relevant, a description of any additional

material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;

7. A description of the Plan's internal appeal procedures (including voluntary appeals) and external review processes, along with the applicable time limits an information on how to initiate an appeal;
8. A statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal;
9. If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;
10. If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge;
11. The availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes.

EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the Affordable Care Act's external review requirements.

If your appeal of a Post-Service Claim is denied, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

Note that external review is only available for the following types of Post-Service Claims:

- A denial that involves medical judgment, including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at the time.

External review is not available for any other types of denials, including if your claims was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, external review is not available for Disability Claims (Weekly Accident and Sickness Benefit).

EXTERNAL REVIEW OF POST-SERVICE CLAIMS

Your request for external review of a denial must be made, in writing, within four months of the date that you receive the denial.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, typically external review of Post-Service claims will only be available for denials of appeals (and not initial claim denials).

Preliminary Review

a. Within five business days of the Plan's receipt of your external review request for a Post-Service claim, the Plan will complete a preliminary review of the request to determine whether you are/were covered under the Plan at the time of the health care item or service is/was requested or provided, you have exhausted the Plan's internal claims and appeals process (except in limited, exceptional circumstances), and you have submitted a complete request.

b. Within one business day of completing its preliminary review, the Plan will notify you in writing as to whether your request made the threshold requirements for external review, and if not, the Plan will notify you as to why your request is not eligible for external review, and/or if you need to submit additional information to perfect your request.

REVIEW BY INDEPENDENT REVIEW ORGANIZATION

If the request is complete and eligible, the Plan will assign the request to an Independent Review Organization, or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan will maintain contracts with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply: The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within 10 business days).

The Plan will timely provided the IRO with the documents and information it considered in making its denial determination.

If you submit additional information related to your claim, the assigned IRO will promptly forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its denial that is the subject of the external review. However, if upon reconsideration, the Plan reverses its denial, it will provide prompt written notice of its decision to you and the IRO. Upon receipt of such notice, the IRO *will terminate its external review.*

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim as if it is new and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO will also observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The assigned IRO's decision notice will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rational for its decision and 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 to you or the Plan under applicable state or federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

EXPEDITED EXTERNAL REVIEW OF CLAIMS

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize y our ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial from an appeal that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a denial from an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from the facility.

AFTER EXTERNAL REVIEW

If, upon external review, the IRO reverses the Plan's denial, upon the Plan's receipt of notice of the reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's denial, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have exhausted all levels of appeal and final decisions have been reached on those appeals, or until the appropriate time frame described above has elapsed since you filed a request for review and you have received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act (ERISA) without exhausting these appeal procedures if the Plan has failed to follow them.

No lawsuit to recover Plan benefits may be started more than ***12 months*** after the date of loss (that is, the date you incurred the expense you are seeking to have the Plan pay) upon which the lawsuit is based. Because the Plan grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, the issue in a lawsuit will be limited to whether or not the Board of Trustees (or its delegates, including the subcommittee for Urgent Care, Pre-Service and Concurrent Care Claims) acted arbitrarily or capriciously in making its determination. No lawsuit to recover Plan benefits may be started more than ***12 months*** after the date the Board of Trustees makes its final decision on an appeal, or after the date the Fund was required but failed to act in accordance with its appeal procedures.

Legal Notices

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under federal (or state) law, 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, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

As required by the Women's Health and Cancer Rights Act of 1998, benefits are provided for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, contact BCBSMA at 800-327-6716.

These benefits will be provided subject to the same deductibles and coinsurance applicable to medical and surgical benefits provided under the Plan's Schedule of Benefits.

New England Carpenters Health Benefits Fund Privacy Notice

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.**

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 89. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we ***never*** share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can **use and disclose** your information to run our organization and contact you when necessary.
We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: http://www.hhs.gov/hipaa/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing, If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
http://www.hhs.gov/hipaa/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Other Instructions for Notice

- Effective date of Notice September 23, 2013
- Contact Privacy Officer:

  New England Carpenters Health Fund
  Attn: Jeffrey W. Werner
  Tel: 978-752-1132
  Email: jwerner@carpentersfund.org

Your ERISA Rights

As a participant in the New England Carpenters Health Benefits 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 are entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- 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 Fund 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, 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 Fund'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, spouse or 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. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other Fund 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 welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim 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 a copy of the Plan documents or the latest annual report 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.

If you have a claim for benefits that 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 Fund's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Fund fiduciaries misuse the Fund'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 your Plan, you should contact the Fund. 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, Pension and Welfare Benefits 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 at the Employee Benefits Security Administration.

Plan Facts

NAME OF PLAN	THE NEW ENGLAND CARPENTERS HEALTH BENEFITS FUND
Type of Plan	A self-funded Employee Health and Welfare Benefit Plan that provides coverage for medical care, prescription drugs, dental care, vision care, weekly accident and sickness benefits, life insurance and accidental death and dismemberment benefits to eligible members and their qualified dependents
Name of Plan Sponsor	Board of Trustees New England Carpenters Health Benefits Fund Fund Office Address 350 Fordham Road, Wilmington, MA 01887
Agent for Service of Legal Process	Service of legal process may be made upon any Fund Trustee.
Plan Administrator	Board of Trustees New England Carpenters Health Benefits Fund
Type of Administration	Collectively Bargained, jointly trusteed labor management trust of the Plan
Plan Number	501
IRS Employer Identification Number	04-2191579
Plan Fiscal Year	January 1 – December 31
Sources of Financing	Payments made to the trust by individual employers under the provisions of the Collective Bargaining or Participation Agreements, employee contributions, and any income earned from investment of employer and employee contributions. The Fund will provide you, upon written request, with information as to whether a particular employer is contributing to this Plan on behalf of participants working under the Collective Bargaining Agreement and, if so, with that employer's address. All monies are used exclusively for providing benefits to eligible employees, early retirees, and their dependents, and the paying of all expenses incurred with respect to the operation of the Plan. The Trustees shall review annually the funding status of the Plan.

The Plan is administered by the Fund and third-party administrators that the Fund contracts with, as listed below.

- **Medical –** the Fund contracts with Blue Cross Blue Shield of Massachusetts (BCBSMA) for a network of preferred providers (PPO), that includes IORA primary care providers who participate with BCBSMA.
- **Dental –** the Fund contracts with Delta Dental of Massachusetts for a network of dental providers for dental benefit administration including administering your dental claims.
- **Vision –** The Fund provides the Carpenters Vision Center, and the Fund contracts with Davis Vision for a network of vision providers, in which the Carpenters Vision Center participates.
- **Prescription Drug –** the Fund contracts with Express Scripts for prescription drug program administration and claims administration, and Diplomat Pharmacy for specialty medications.

- **Employee Assistance Program –** the Fund contracts with KGA.
- **Life Insurance and Accidental Death and Dismemberment –** benefits are underwritten by Unum.

THE BOARD OF TRUSTEES

The Board of Trustees is made up of an equal number of Employer Representatives and Union Representatives who serve without compensation. Under a Trust Agreement, the Board has full authority and discretion to operate and administer this Plan.

Discretionary Authority of the Board of Trustees

The Board of Trustees has complete and exclusive discretionary authority to (i) establish, adopt, amend, or discontinue all or part of the Plan of Benefits provided by this Fund at any time; (ii) establish, adopt, and amend any instruments, forms, policies, or documents by which the Trust Agreement or Plan is administered or implemented; (iii) establish, adopt, amend, and determine rules governing participation in the plan and the scope of covered benefits; (iv) investigate and make all factual determinations necessary to decide questions of eligibility for participation in the Fund and the application of the terms of the Plan to claims for benefits and all other matters; and (v) construe and interpret the terms of the Trust Agreement, Plan, or any other instruments, forms, policies, or documents of the Plan, including disputed or ambiguous terms and meanings. The determinations and interpretations made by the Trustees pursuant to this authority are binding and final on all participants, dependents, and all other interested persons. Benefits are not vested, and provisions may change after the date of this Summary Plan Description. Contact the Fund Office if you have questions regarding eligibility or current benefits.

FRAUD, MISREPRESENTATION, AND FAILURE TO NOTIFY THE FUND

- In the event that any participant, dependent, or other individual engages in or participates in any fraud with respect to his or her participation in or coverage by the Plan, or with respect to the participation or coverage by the Plan of any other individual, or with respect to an employer's participation in the Plan, or otherwise submits any false or misleading reports, representations, information, or other statements to the Plan, or fails to submit any information that he or she is required to submit to the Plan or to do so in a timely manner, the Trustees shall have the right to take such action as they deem appropriate.
- Such action may include, but not be limited to, recoupment of any overpayments by reducing the amount of future benefits to the participant and/or all otherwise eligible dependents until the overpayment is recovered, and retroactive termination or rescission of the coverage of the participant and/or all dependents.
- If any act or omission by a participant, dependent, or other individual or entity results in the Plan providing benefits on behalf of any individual who is not entitled to such benefits under the terms of the Plan, such participant, dependent, or other individual or entity shall be liable to the Plan for any overpayments plus interest, and for any costs and attorneys fees incurred by the Plan in connection with any legal proceeding undertaken by the Plan or the Trustees to recover such overpayments.

COLLECTIVE BARGAINING AGREEMENT

A Collective Bargaining Agreement is a written agreement between a union and an employer that requires the employer to make contributions to the Fund on behalf of its employees. To inquire about whether a particular employer contributes to this Fund, or to request a copy of the Collective Bargaining Agreement, contact the Fund Office.

PLAN AMENDMENT AND TERMINATION

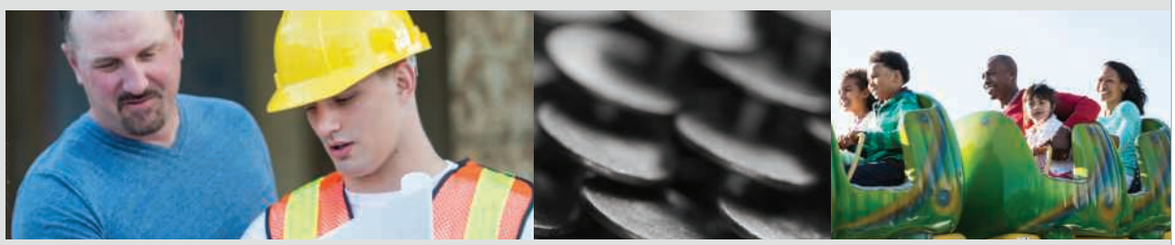
The Board of Trustees reserves the right to terminate or amend the Plan including the right to amend or terminate benefits or eligibility for any class of participant, including retirees, when in their sole discretion they determine such action is in the best interest of the Fund and its participants. Eligibility requirements are reviewed regularly by the Trustees.

In addition, the Plan may be terminated by the Trustees if there is no longer an agreement in effect between the Employers and the Union requiring contributions to the Health Benefits Fund.

Should the Plan terminate, the Trustees will apply remaining assets of the Fund to continue benefits beyond the date of termination. The Trustees reserve the right to amend the eligibility rules at the time of termination. Retiree benefits are funded from current contributions and are not guaranteed or vested. In any case, the Trustees will use any remaining assets of the Fund to provide benefits and pay administration expenses or otherwise to carry out the purpose of the Plan in accordance with the Plan Document and Trustee Agreement until the entire remainder of the Fund has been disbursed.

GLOSSARY OF TERMS

NEW ENGLAND CARPENTERS



HEALTH BENEFITS FUND

Glossary of Terms

This section defines some of the terms used in this document. Please take the time to read these terms carefully. They will help you to better understand your benefits. Also, in order for benefits to be payable, the expenses must meet the requirements of these terms.

Allowed Amount (Allowed Expense, Allowed Charge) is the maximum amount the Plan will pay for a covered service, based on the amounts normally charged for similar services and supplies in your area. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Ambulatory Surgical Facility means an establishment licensed as such by the state with an organized medical staff of physicians with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous physician services and registered professional nursing services whenever a patient is in the facility.

Coinsurance – Once you satisfy the calendar year deductible, depending on the type of service you receive, the Fund may pay a percentage of the total covered expenses. The remaining percentage is your share, or coinsurance amount. Refer to the Schedule of Benefits, beginning on page 97, for specific coinsurance information.

Copayment means a flat dollar amount that you pay for certain services that are covered under the Plan. For example, doctor's office visits in the PPO network for Plan I require a $15 copayment.

Covered Employment means working for a contributing employer who is obligated to make contributions to the Fund in accordance with a collective bargaining agreement/participation agreement.

Covered Medical Expenses means expenses for medical (including prescription drug, vision, hearing, mental health and substance abuse treatment) and/or dental services or supplies, but only to the extent that:

- they are Medically Necessary, as defined in this glossary; and
- the charges for them are the negotiated fees for in-network services or the allowed amount for out-of-network services; and
- coverage for the services or supplies is not excluded, as provided in the General Exclusions Section.

Custodial Services means any services that are not intended primarily to treat a specific injury or sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods or taking medications that can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible is the amount you (and/or your family) must pay in medical expenses before the Fund will begin to pay benefits. The amount of your calendar year deductible depends on the Plan of Benefits you're covered under. Please refer to the Schedule of Benefits to determine which medical services require you to meet an annual deductible before the Plan pays benefits.

Eligible Dependent means (1) your lawful spouse; (2) your children (including a legally adopted child and/or a stepchild or foster child who depends upon you for support and maintenance and has been reported to the Fund Office. See page 51 for details.

Emergency Treatment means treatment for an injury or sudden serious illness that poses an urgent or pressing need and is treated within hours of the commencement of the illness or injury.

Experimental Treatment/Procedure means a treatment or procedure performed to demonstrate a known truth, examine the validity of a hypothesis, to determine the efficacy of something previously untried or which has not been proven.

Extended Care Facility means an institution or a distinct part of an institution which:

- is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, skilled nursing care for patients who require medical care because of injury or sickness;
- provides 24-hour-a-day nursing service under the supervision of a full-time employee who is either a doctor or a registered nurse;
- maintains clinical records on all patients;
- provides for having a doctor available to furnish necessary medical care in case of emergency; and
- provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

In no event shall "Extended Care Facility" include any institution or part of an institution which is a hospital or which is primarily for the care of mental illness, drug addiction, alcoholism or tuberculosis or which is primarily engaged in providing domiciliary, custodial or educational care or care for the aged.

Free-standing Diagnostic Facility, or an independent diagnostic facility is one that is independent of a physician office or hospital; that is, it is not owned by a hospital, individual physician or group practice of physicians and its purpose is to furnish diagnostic tests and not to directly use test results to treat a patient.

Home Health Aide means a person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency means an agency or organization (or a distinct part of) which:

- is primarily engaged in providing skilled nursing and other therapeutic services for and in the private residence of participants recovering from an injury or sickness;
- is properly licensed or approved according to any applicable state or local standards and is federally certified as a Home Health Care Agency;
- is operated according to policies established by a professional staff including at least one physician and at least one registered nurse;
- provides for supervision of its services by a physician or a registered nurse;
- maintains medical records for all patients.

Hospital means an institution operated pursuant to law which is primarily engaged in providing for compensation from its patients medical, surgical and diagnostic facilities for the care and treatment of sick and injured persons on an inpatient basis and which provides such facilities under the supervision of a staff of physicians and with 24- hour-a-day nursing services by registered graduate nurses. Unless it meets this definition, the term "hospital" shall not include any institution or part thereof that is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged. A licensed institution used principally for the care and treatment of alcoholics will be included under the definition of "hospital" with the applicable coverage in accordance with the schedule of benefits for which you or a family participant are eligible for confinement in such institution. A licensed institution used principally for the care and treatment of mental illness will be included under the definition of "hospital" with the applicable coverage for confinement in such institution in accordance with the Schedule of Benefits for which you or a family participant are eligible.

Hospital Charges, Surgical Charges and Medical Charges means the charges for covered medical expenses, which are:

- made by a legally constituted hospital for board and room and for other hospital services and supplies (but not including charges for special nursing services or for services for physicians or surgeons) furnished by the hospital during confinement;
- the term "surgical charges" means the charges for covered medical expenses for surgery and for necessary post-operative treatment in connection with the surgery;
- the term "medical charges" means those charges for covered medical expenses that are other than hospital charges or surgical charges as defined above.

Hospital Confinement includes successive periods of hospital confinement for the same or a related disease or bodily injury unless separated by complete recovery from the disease or bodily injury, which caused the previous period of hospital confinement or, in the case of the Participant, a return to active work for at least one day.

Hospice Care Facility means an institution that provides care and service for terminally ill persons and which:

- provides 24-hour-a-day nursing care for the terminally ill person with the necessary physical, psychological and spiritual needs, with acute inpatient and outpatient care, home care, bereavement counseling directly or indirectly;
- has a medical director who is a physician;
- has an interdisciplinary team that coordinates the care and services it provides and which includes at least one physician, one registered professional nurse and one social worker;
- maintains central clinical records on all patients; and
- is licensed or accredited as a Hospice if required.

Medically Necessary means any service, supply, treatment or hospital confinement (or part of a hospital confinement) which is **essential** to the treatment of the injury or illness for which it is prescribed or performed, meets generally accepted standards of medical practice and is ordered by a physician. **The fact that a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the expense a Covered Charge.**

Participant means an individual who is or was employed by a contributing employer in covered employment and on whose behalf the employer was obligated to make contributions to the Fund, and who has satisfied the eligibility requirements to receive health benefits under one of the Plans.

Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to diagnose, prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the services are rendered if he is:

- operating within the scope of his license, and
- performing a service for which benefits are provided under this plan when performed by a physician.

Surrogate is defined as a person who becomes pregnant through artificial or assisted reproductive methods for the purpose of carrying the fetus to term for a third party with the knowledge, understanding, or agreement that the child will be relinquished to a third party following its birth.

SCHEDULE OF BENEFITS FOR

PLAN I, PLAN II AND THE RETIREE HEALTH BENEFITS PLAN

NEW ENGLAND CARPENTERS

HEALTH BENEFITS FUND

Schedules of Medical Benefits

SCHEDULE OF MEDICAL BENEFITS FOR PLAN I

Your Annual Deductible	$300 per person $600 per family
Your Annual Out-Of-Pocket Maximum for Medical Expenses	$2,000 per person $4,000 per family
Annual Plan Maximum	No Maximum

BENEFIT	PLAN PAYS PPO NETWORK	PLAN PAYS OUT-OF-NETWORK
Ambulance Service Air/Ground Transport	80% after deductible Air Ambulance service payable for life-threatening emergency	80% after deductible Air Ambulance service payable for life-threatening emergency
Cardiac Rehabilitation	80% after deductible when medically necessary following heart attack or stroke	75% after deductible when medically necessary following heart attack or stroke
Chiropractic Care	100% after $15 copay per visit to a calendar year maximum of 20 visits per person	75% after deductible to a calendar year maximum of 20 visits per person
Diagnostic Laboratory and X-Ray	80% after deductible	75% after deductible
Durable Medical Equipment (requires physician letter of medical necessity)	80% after deductible Payments will not exceed the actual purchase price	75% after deductible Payments will not exceed the actual purchase price
Emergency Room (physician professional fees)	100%	100%
Emergency Room (hospital facility fees)	$100 copay per visit (copay waived if admitted) ("Admitted" means: Inpatient; patient kept for observation; Emergency Surgery including OR & Recovery)	$100 copay per visit (copay waived if admitted) ("Admitted" means: Inpatient; patient kept for observation; Emergency Surgery including OR & Recovery)
Hearing Aids (through Hear USA)	Up to $1,500 per hearing aid per ear to a maximum of $3,000 once every three-year period. Children up to the age of 19 once every year. (Benefit applies in-network or out-of-network)	
Home Health Care (requires prior authorization)	80% after deductible See page 17 for specific coverage information	75% after deductible See page 17 for specific coverage information

SCHEDULE OF MEDICAL BENEFITS FOR PLAN I (CONTINUED)

BENEFIT	PLAN PAYS PPO NETWORK	PLAN PAYS OUT-OF-NETWORK
Hospice Care (home hospice care requires prior authorization)	80% after deductible	75% after deductible
Hospital Room and Board (requires prior authorization)	80% after deductible	75% after deductible
Hospital Physicians Expense Benefit	80% after deductible	75% after deductible
Infertility Treatment (physician professional fees)	80% after deductible (limited to 2 IVFs per lifetime)	75% after deductible (limited to 2 IVFs per lifetime)
Collection and Storage of Sperm (cancer patients undergoing chemotherapy and/or radiation therapy)	100% lifetime maximum $1,000	100% lifetime maximum $1,000
Mental Health Treatment (Inpatient/Residential) (requires prior authorization)	80% after deductible	75% after deductible
Mental Health Treatment (Partial Hospitalization/Intensive Outpatient) (requires prior authorization)	80% after deductible	75% after deductible
Mental Health Treatment (Outpatient)	100% after a $15 copay per visit	75% after deductible
MRI/CT Scan	80% after deductible	75% after deductible
Occupational Therapy	100% after a $15 copay per visit	75% after deductible
Office Visits (Illness)	100% after a $15 copay per visit	75% after deductible
Organ Transplants	Limited to $500,000 per inpatient admission 80% after deductible	Limited to $500,000 per inpatient admission 75% after deductible
Physical Exams (includes routine immunizations)	100%	75% after deductible
Physical Therapy	100% after a $15 copay per visit	75% after deductible

BENEFIT	PLAN PAYS PPO NETWORK	PLAN PAYS OUT-OF-NETWORK
Podiatrist Services	100% after a $15 copay per visit up to a calendar year maximum of $500 per person	75% after deductible up to a calendar year maximum of $500 per person
Skilled Nursing Facility (requires prior authorization)	80% after deductible	75% after deductible
Speech Therapy	80% after deductible	75% after deductible
Substance Abuse Treatment (Inpatient/Residential) (requires prior authorization)	80% after deductible	75% after deductible
Substance Abuse Treatment (Partial Hospitalization/Intensive Outpatient) (requires prior authorization)	80% after deductible	75% after deductible
Substance Abuse Treatment (Outpatient)	100% after a $15 copay per visit	75% after deductible
Surgeon's Expenses	80% after deductible	75% after deductible
Temporomandibular Joint Disorders (TMJ)	80% after deductible to a lifetime maximum of $1,500 per person, within limitations stated in the Plan exclusions (page 69)	75% after deductible to a lifetime maximum of $1,500 per person, within limitations stated in the Plan exclusions (page 69)

SCHEDULE OF MEDICAL BENEFITS FOR PLAN II

Your Annual Deductible	$500 per person $1000 per family
Your Annual Out-Of-Pocket Maximum for Medical Expenses	$3,200 per person $6,400 per family
Annual Plan Maximum	No Maximum

BENEFIT	PLAN PAYS PPO NETWORK	PLAN PAYS OUT-OF-NETWORK
Ambulance Service Air/Ground Transport	70% after deductible Air Ambulance service payable for life-threatening emergency	70% after deductible Air Ambulance service payable for life-threatening emergency
Cardiac Rehabilitation	70% after deductible when medically necessary following heart attack or stroke	60% after deductible when medically necessary following heart attack or stroke
Chiropractic Care	100% after $15 copay per visit to a calendar year maximum of 20 visits per person	60% after deductible to a calendar year maximum of 20 visits per person
Diagnostic Laboratory and X-Ray	70% after deductible	60% after deductible
Durable Medical Equipment (requires physician letter of medical necessity)	70% after deductible Payments will not exceed the actual purchase price	60% after deductible Payments will not exceed the actual purchase price
Emergency Room (physician professional fees)	100%	100%
Emergency Room (hospital facility fees)	$100 copay per visit (copay waived if admitted) ("Admitted" means: Inpatient; patient kept for observation; Emergency Surgery including OR & Recovery)	$100 copay per visit (copay waived if admitted) ("Admitted" means: Inpatient; patient kept for observation; Emergency Surgery including OR & Recovery)
Hearing Aids (through Hear USA)	Up to $1,500 per hearing aid per ear to a maximum of $3,000 once every three-year period. Children up to the age of 19 once every year. (Benefit applies in-network or out-of-network)	
Home Health Care (requires prior authorization)	70% after deductible See page 17 for specific coverage information	60% after deductible See page 17 for specific coverage information
Hospice Care (home hospice care requires prior authorization)	70% after deductible	60% after deductible
Hospital Room and Board (requires prior authorization)	70% after deductible	60% after deductible
Hospital Physicians Expense Benefit	70% after deductible	60% after deductible
Infertility Treatment (physician professional fees)	70% after deductible (limited to 2 IVFs per lifetime)	60% after deductible (limited to 2 IVFs per lifetime)

BENEFIT	PLAN PAYS PPO NETWORK	PLAN PAYS OUT-OF-NETWORK
Collection and Storage of Sperm (cancer patients undergoing chemotherapy and/or radiation therapy)	100% lifetime maximum $1,000	100% lifetime maximum, $1,000
Mental Health Treatment (Inpatient/Residential) (requires prior authorization)	70% after deductible	60% after deductible
Mental Health Treatment (Partial Hospitalization/Intensive Outpatient) (requires prior authorization)	70% after deductible	60% after deductible
Mental Health Treatment (Outpatient)	100% after a $15 copay per visit	75% after deductible
MRI/CT Scan	70% after deductible	60% after deductible
Occupational Therapy	100% after a $15 copay per visit	60% after deductible
Office Visits (Illness)	100% after a $15 copay per visit	75% after deductible
Organ Transplants	Limited to $500,000 per inpatient admission 70% after deductible	Limited to $500,000 per inpatient admission 60% after deductible
Physical Exams (includes routine immunizations)	100%	60% after deductible
Physical Therapy	100% after a $15 copay per visit	60% after deductible
Podiatrist Services	100% after a $15 copay per visit up to a calendar year maximum of $500 per person	60% after deductible up to a calendar year maximum of $500 per person
Skilled Nursing Facility (requires prior authorization)	70% after deductible	60% after deductible
Speech Therapy	70% after deductible	60% after deductible
Substance Abuse Treatment (Inpatient/Residential) (requires prior authorization)	70% after deductible	60% after deductible
Substance Abuse Treatment (Partial Hospitalization/Intensive Outpatient) (requires prior authorization)	70% after deductible	60% after deductible
Substance Abuse Treatment (Outpatient)	100% after a $15 copay per visit	60% after deductible
Surgeon's Expenses	70% after deductible	60% after deductible
Temporomandibular Joint Disorders (TMJ)	70% after deductible to a lifetime maximum of $1,500 per person, within limitations stated in the Plan exclusions (page 69)	60% after deductible to a lifetime maximum of $1,500 per person, within limitations stated in the Plan exclusions (page 69)

SCHEDULE OF MEDICAL BENEFITS FOR THE RETIREE HEALTH BENEFITS PLAN

Your Annual Deductible	$350 per person $700 per family
Your Annual Out-Of-Pocket Maximum for Medical Expenses	$3,000 per person $6,000 per family
Annual Plan Maximum	No Maximum

BENEFIT	PLAN PAYS PPO NETWORK	PLAN PAYS OUT-OF-NETWORK
Ambulance Service Air/Ground Transport	80% after deductible Air Ambulance service payable for life-threatening emergency	80% after deductible Air Ambulance service payable for life-threatening emergency
Cardiac Rehabilitation	80% after deductible when medically necessary following heart attack or stroke	80% after deductible when medically necessary following heart attack or stroke
Chiropractic Care	100% after $15 copay per visit to a calendar year maximum of 20 visits per person	80% after deductible to a calendar year maximum of 20 visits per person
Diagnostic Laboratory and X-Ray	100%	80% after deductible
Durable Medical Equipment (requires physician letter of medical necessity)	80% after deductible Payments will not exceed the actual purchase price	80% after deductible Payments will not exceed the actual purchase price
Emergency Room (physician professional fees)	80% after deductible	80% after deductible
Emergency Room (hospital facility fees)	$100 copay per visit (copay waived if admitted) ("Admitted" means: Inpatient; patient kept for observation; Emergency Surgery including OR & Recovery)	$100 copay per visit (copay waived if admitted) ("Admitted" means: Inpatient; patient kept for observation; Emergency Surgery including OR & Recovery)
Hearing Aids (through Hear USA)	Up to $1,500 per hearing aid per ear to a maximum of $3,000 once every three-year period. Children up to the age of 19 once every year. (Benefit applies in-network or out-of-network)	
Home Health Care (requires prior authorization)	See page 17 for specific coverage information	See page 17 for specific coverage information
Hospice Care (home hospice care requires prior authorization)	100% after deductible	85% after deductible
Hospital Room and Board (requires prior authorization)	$250 copay then 80%	$250 copay then 80%
Hospital Physicians Expense Benefit	80% after deductible	80% after deductible
Infertility Treatment	Not Covered	Not Covered
Mental Health Treatment (Inpatient/Residential) (requires prior authorization)	$250 copay then 80%	$250 copay then 80%

BENEFIT	PLAN PAYS PPO NETWORK	PLAN PAYS OUT-OF-NETWORK
Mental Health Treatment (Partial Hospitalization/Intensive Outpatient) (requires prior authorization)	80% after deductible	80% after deductible
Mental Health Treatment (Outpatient)	100% after a $15 copay per visit	80% after deductible
MRI/CT Scan	100% when performed at a free-standing radiology facility or doctor's office; otherwise a $150 copayment applies* *Copay waived if no free-standing facility within 30-mile radius of home	80% after deductible when performed at a free-standing facility or doctor's office; otherwise a $150 copayment applies* *Copay waived if no free-standing facility within 30-mile radius of home
Occupational Therapy	100% after a $15 copay per visit	100%
Office Visits (Illness)	100% after a $15 copay per visit	80% after deductible
Organ Transplants	Limited to $500,000 per inpatient admission $250 copay then 80%	Limited to $500,000 per inpatient admission $250 copay then 70%
Physical Exams (includes routine immunizations)	100%	80% after deductible
Physical Therapy	100% after a $15 copay per visit	80% after deductible
Podiatrist Services	100% after a $15 copay per visit up to a calendar year maximum of $500 per person	80% after deductible up to a calendar year maximum of $500 per person
Skilled Nursing Facility (requires prior authorization)	$250 copay then 80%	$250 copay then 80%
Speech Therapy	80% after deductible	80% after deductible
Collection and Storage of Sperm (cancer patients undergoing chemotherapy and/or radiation therapy)	100% lifetime maximum $1,000	100% lifetime maximum $1,000
Substance Abuse Treatment (Inpatient/Residential) (requires prior authorization)	$250 copay then 80%	$250 copay then 80%
Substance Abuse Treatment Partial Hospitalization/Intensive Outpatient (requires prior authorization)	80% after deductible	80% after deductible
Substance Abuse Treatment (Outpatient)	100% after a $15 copay per visit	80% after deductible
Surgeon's Expenses	80% after deductible	80% after deductible
Temporomandibular Joint Disorders (TMJ)	Not Covered	Not Covered

Dental (Plan I Only)

The following chart shows the benefits payable when you use a participating Delta Dental provider. For out-of-network benefits, you will be billed for any amount that your out-of-network dentist charges that is more than the pre-negotiated Delta Dental network charge. Please refer to your Delta Dental benefits guide for more specific coverage information, or visit **www.deltadentalma.com**

DELTA DENTAL PPO PLUS PREMIER

Group Number	007525-9001
Annual Deductible	None
Calendar Year Benefit Maximum	$2,500 per person

CATEGORY/PROCEDURE	QUALIFICATIONS	PLAN PAYS IN-NETWORK	PLAN PAYS OUT-OF-NETWORK
TYPE I DIAGNOSTIC		100%	You are responsible for paying any amount that your out-of-network dentist charges that is more than the pre-negotiated Delta Dental network charge.
Comprehensive evaluation	Once every 60 months		
Periodic oral exams	Twice per calendar year		
Full mouth X-rays	Once every 36 months		
Bitewing X-rays	Twice per calendar year		
Single tooth X-rays	As needed		
Preventive			
Teeth cleaning	Twice per calendar year		
Flouride treatments	Twice per calendar year (under age 19)		
Space maintainers	Required due to the premature loss of teeth. For dependents under age 14 and not for the replacement of primary or permanent anterior teeth		

** You are responsible for paying any amount that your out-of-network dentist charges that is more than the pre-negotiated Delta Dental network charge.*

CATEGORY/PROCEDURE	QUALIFICATIONS	PLAN PAYS IN-NETWORK	PLAN PAYS OUT-OF-NETWORK*
Sealants	Unrestored permanent molars, every 4 years per tooth for dependents through age 15. Sealants are also covered for dependents age 16 up to age 19 for those who had a recent cavity and are at risk for decay	100%	You are responsible for paying any amount that your out-of-network dentist charges that is more than the pre-negotiated Delta Dental network charge
Chlorhexidine mouth rinse	This is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing	100%	
Fluoride toothpaste	This is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery	100%	
TYPE II RESTORATIVE		80%	80%*
Silver fillings and white fillings (front teeth)	Once every 24 months per surface per tooth		
White fillings (back teeth)	Covered only for single surfaces. Once every 24 months, per surface, per tooth, multi-surfaces will be processed as a silver filling and the patient is responsible up to the submitted charge		
Temporary fillings	Once per tooth		
Stainless steel crowns	Once every 24 months per primary tooth, after a pulpotomy		
PERIODONTICS			
Periodontic surgery	One surgical procedure per quadrant in 36 months	80%	80%*
Scaling and root planing	Once in 24 months, per quadrant	80%	80%*
Periodontal cleaning	Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings	100%	100%*

** You are responsible for paying any amount that your out-of-network dentist charges that is more than the pre-negotiated Delta Dental network charge.*

DELTA DENTAL PPO PLUS PREMIER (CONTINUED)

CATEGORY/PROCEDURE	QUALIFICATIONS	PLAN PAYS IN-NETWORK	PLAN PAYS OUT-OF-NETWORK*
ENDODONTICS		80%	80%*
Root canal treatment	Once per tooth		
Vital pulpotomy	Limited to deciduous teeth		
PROSTHETIC MAINTENANCE		80%	80%*
Bridge or denture repair	Once within 12 months, same repair		
Rebase or reline of dentures	Once within 36 months		
Recement crowns and onlays	Once per tooth		
EMERGENCY DENTAL CARE		80%	80%*
Minor treatment for pain relief	Three occurrences in 12 months		
General anesthesia (IV sedation)	Only allowed with covered surgical impacted wisdom teeth		
TYPE III PROSTHODONTICS		50%	50%*
Dentures	Once within 60 months		
Fixed bridges and crowns when part of a bridge	Once within 60 months		
Implants—only in lieu of a three-unit bridge	An Endosteal implant: only when it is to replace one missing tooth and when all adjacent teeth are healthy and do not require crowns. Once per 60 months per implant. (Pre-estimates recommended)		
MAJOR RESTORATIVE		50%	50%*
Crowns	When teeth cannot be restored with regular fillings. Once within 60 months per tooth		
ORTHODONTIA	Covered at 100% of Maximum Plan Allowance charges to any age. $2,000 separate Lifetime Maximum (per person)		

** You are responsible for paying any amount that your out-of-network dentist charges that is more than the pre-negotiated Delta Dental network charge.*

Vision Care – Davis Vision Premier Plan Benefits

(Through the Carpenters Care Vision Center or a Davis Vision Provider)

BENEFIT	FREQUENCY	IN-NETWORK COPAY	IN-NETWORK COVERAGE
Eye Examination[4]	24 months, every 12 months for dependent children (up to age 19)	$0	Covered in full. Includes dilation when professionally indicated
Spectacle Lenses	24 months, every 12 months for dependent children (up to age 19)	$0	Clear plastic lenses in any single vision, bifocal, trifocal, or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frames	24 months, every 12 months for dependent children (up to age 19)	$0	Covered in Full Frames: Any Fashion, Designer or Premier level frame from Davis Vision's Collection (retail value up to $225). OR, Frame Allowance: $35 toward any frame from provider plus 15% off any balance. No copay required.
Contact Lens Evaluation, Fitting and Follow-up Care	24 months, every 12 months for dependent children (up to age 19)	$25	Davis Vision Collection[1] Contacts: After copay, covered in full Standard Soft Contacts: After copay, covered in full
Contact Lenses (in lieu of eyeglasses)	24 months, every 12 months for dependent children (up to age 19)	$0	Covered in Full Contacts: From Davis Vision's Collection[1], up to: Planned Replacement Two boxes/multi packs Disposable Four boxes/multi packs OR, Contact Lens Allowance: $55 allowance toward any contacts from provider's supply
Safety Eyeglasses (participants only, in lieu of dress pair)	24 months	$0	Covered in Full Safety Frames: Fashion level frame from Davis Vision's Safety Collection[5]

VISION CARE — DAVIS VISION PREMIER PLAN BENEFITS (CONTINUED)

Significant savings on optional frames, lens types and coatings

	PARTICIPANT PRICE	
	DRESS	SAFETY
Davis Vision Collection Frames: Fashion/Designer/Premier	$0/$0/$20[7]	$0/$15/$40
Tinting of Plastic Lenses	$0	$0
	PARTICIPANT PRICE	
	DRESS	SAFETY
Oversize Lenses	$0	$0
Scratch-resistant Coating	$0	$0
Ultraviolet Coating	$12	$12
Anti-reflective Coating Standard/Premium/Ultra	$35/$48/$60	$35/NA/NA
Polycarbonate Lenses	$0[3] - $30	$30[5]
High-index Lenses	$55	$55
Progressive Lenses Standard/Premium	$0/$50	$0/$50
Polarized Lenses Standard/Premium	$75	$75
Photosensitive Lenses Plastic/Glass	$65/$20	$65/N/A
Blended Invisible Bifocals	$0	$0
Intermediate-Vision Lenses	$30	$30
Scratch Protection Plan Single Vision/ Multifocal Lenses	$20/$40	N/A

1. *The Davis Vision Collection is available at most participating independent provider locations.*
2. *Including, but not limited to, toric multifocal and gas permeable contact lenses.*
3. *For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.*
4. *By utilizing the safety eyeglass benefit with the comprehensive dress eyewear plan, one eye examination will cover both requirements.*
5. *Davis Vision's Safety Frame Collection meets or exceeds the [Z87 1] American National Standard and the requirements of the Occupational Safety and Health Administration (OSHA) for impact resistance.*
6. *Polycarbonate lenses meet or exceed the Z87 1 American National Standard and the requirements of the Occupational Safety and Health Administration (OSHA) for impact resistance.*
7. *If two premiere frames are selected in conjunction with DV/NV in lieu of a bifocal, one $20 copayment applies.*

Please note your provider reserves the right to not disburse materials until all applicable participant costs, fees and copayments have been collected.

Contact lenses. Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the participant. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses.

Progressive lenses. If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost, however, your copayment is non-refundable. May not be combined with other discounts or offers. Please be advised that these lens options and copayments apply to in-network benefits.

Life Insurance (Plans I & II)

BENEFIT	PLAN I OR PLAN II
Your Life	$20,000
Your Spouse	$2,000

Accidental Death & Dismemberment (Plans I & II)

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE FOR PARTICIPANT ONLY		
	PLAN I	PLAN II
Loss of life or loss of movement of both upper and lower limbs (quadriplegia). Loss of both hands or both feet or sight in both eyes	$20,000	$20,000
Loss of one hand, one foot, speach or hearing in both ears, or either one hand or one foot and sight of one eye	$20,000	$20,000
Loss of movement of three limbs (Triplegia) or both lower limbs (Paraplegia)	$15,000	$15,000
Loss of a hand, a foot, an eye, speech or hearing. Loss of movement of both upper and lower limbs on one side of the body (hemiplegia)	$10,000	$10,000
Loss of thumb and index finger on either hand or loss of movement of one limb (uniplegia)	$5,000	$5,000

Weekly Accident and Sickness (Plan I Only)

	ACCIDENT	ILLNESS
When Benefits Begin	Day I (Accident)	Day 8 (Illness)
Maximum Benefit Duration	26 weeks	26 weeks
Maximum Benefit	$500 per week	$500 per week

Notes

Notes

New England Carpenters
Health Benefits Fund

350 Fordham Road
Wilmington, MA 01887
978-694-1000
800-344-1515