NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

UNION TRUSTEES
Michael J. Forde
Chairman
Peter Thomassen
Denis Sheil III
Vincent Alongi
Lawrence D'Errico
John E. Greaney

MANAGEMENT TRUSTEES
Richard Harding
Co-Chairman
George Greco
Michael Mazzucca
David Meberg
Paul O'Brien
Joseph Olivieri

NEW MEMBER ASSISTANCE PROGRAM & BEHAVIORAL HEALTH BENEFIT CHANGES EFFECTIVE OCTOBER 1, 2003 (Actives)

Dear Participant:

The Trustees of the New York City District Council of Carpenters Welfare Fund wish to advise you of important benefit changes effective October 1, 2003.

We are pleased to introduce a new benefit called the Member Assistance Program (MAP). This benefit is available to all eligible participants and their qualified dependents. The Member Assistance Program (MAP) provides up to 8 face to face counseling sessions per presenting issue. This benefit is free of charge to you and your dependents. MAP services are available 24 hours a day/seven days a week, and are completely confidential. The toll-free access telephone number for MAP services: 1-888-325-3986.

The current benefits for mental health and substance abuse care will not change and remain in effect on October 1, 2003. The toll-free access telephone number for these services is the same as the MAP: 1-888-325-3986. Please refer to the brochure that is enclosed for an outline of your benefits.

CIGNA Behavioral Health has been retained to administer both the MAP and Behavioral Health Programs effective October 1, 2003. Please note that claims for mental health and substance abuse services rendered prior to October 1, 2003 should continue to be submitted to Empire BlueCross BlueShield for consideration.

Transition of Care:

Inpatient Treatment: If you or a dependent is receiving mental health or substance abuse ***inpatient*** care on and after October 1, 2003, you should contact CIGNA at 1-888-325-3986 to make them aware of your situation. You may complete your treatment with your current provider/facility, but any hospital services after this inpatient stay (transitioning to an alternative level of care) must be pre-certified by CIGNA to receive your highest level of benefit coverage.

Outpatient Treatment: If you or a dependent is currently receiving mental health or substance abuse ***outpatient*** care, you should contact CIGNA by October 31, 2003 to discuss your care and see if your provider is in the

(over)

network. Additionally, you can check your provider's status on the Website at www.cignabehavioral.com. If your provider is not in the network, your outpatient claims will be paid at the lower level of coverage beginning January 1, 2004. Please note, we are providing a three month transition period from October 1, 2003 through December 31, 2003 where all outpatient claims will be paid at in-network rates for individuals already receiving outpatient treatment. If your provider is interested in joining the CIGNA Network, please give the enclosed letter to your outpatient provider as soon as possible so that CIGNA can begin discussions with your provider.

To ensure a smooth transition, CIGNA will begin accepting participant phone calls on September 1, 2003. Although the benefits will not be effective until October 1, 2003, CIGNA can answer any plan coverage, transition of care, provider network, claim questions etc. you may have. Simply call 1-888-325-3986 for assistance.

You may also call the Fund office for assistance at (800) 529-3863.

Sincerely,

BOARD OF TRUSTEES
NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

Why Use An In-Network Provider?

When you use a provider from the CIGNA Behavioral network, you're assured that they are properly credentialed and licensed. In addition, all paperwork and claims for your care will be handled by CIGNA Behavioral Health.

You'll also have less out-of-pocket expenses than when you use an out-of-network provider.

If you choose an out-of-network provider, you must also file a claim. To submit an out-of-network claim, send to: CIGNA Behavioral Health
P.O. Box 46270
Eden Prairie, MN 55344
If you have any questions about claims or need a claim form, call toll-free 1-888-325-3986 for assistance.

Tear-off the cards below and keep one in your purse, wallet, or other handy place so you'll always be able to go online or make that telephone call when you need assistance.

www.cignabehavioral.com
Online access to information, benefits, educational materials and more.

1. Log in
2. Enter "carpenters" (in lowercase letters with no spaces) for your Employer ID

quick • easy • confidential • self-paced

www.cignabehavioral.com
Online access to information, benefits, educational materials and more.

1. Log in
2. Enter "carpenters" (in lowercase letters with no spaces) for your Employer ID

quick • easy • confidential • self-paced

Making the Online Connection

Does Your Website Have Reference Articles on Behavioral Health? Thousands of thoroughly researched, frequently updated, easy-to-read articles are housed in the Article Library for easy, 24-hour retrieval. The articles cover everything from depression, alcohol and drug abuse, to panic attacks, anxiety disorder, child care and elder care issues. The library includes tips for prevention, recognition, treatment and successful coping with a range of life's challenges.

Can I Find A Provider Online? Yes. You'll find thousands of providers that have met our strict credentialing requirements to be a part of our network. You can even search for a provider according to criteria such as gender and location, so you can choose a provider you're most comfortable with.

How Does the Self-Assessment Tool Work? When you use the self-assessment tool, you respond to a series of questions at your own pace, in complete confidentiality, to get a sense of your well-being regarding behavioral issues such as depression, anxiety disorder, stress, substance abuse and more. Your answers are automatically analyzed to provide you with an appropriate course of action. This could mean scheduling an in-person counseling session, reading specific articles or getting additional guidance from other sources.

Is My Online Information Confidential? Yes. The same state and federal laws that dictate confidentiality in face-to-face counseling also apply to online information.

Are There Any Time Limits To My Usage? No. You can spend as much time as you want making use of your online benefits. Even better is the fact that, once you're registered, you can access this wide-ranging, useful tools, information and resources 24-hours a day from any computer that has an Internet connection.

Reach us online or call us today.

www.cignabehavioral.com

1-888-325-3986

25-215726 (01/08)

well BEING

we can help

[redacted]

Your MAP and Behavioral Care Benefits - Actives

SERVICE	IN-NETWORK	OUT-OF-NETWORK
MAP 1-8 sessions	100% of charges	None
Deductible	None	$200 Individual/ $500 Family
Mental Health		
Outpatient Visits in Office or Facility (Up to 60 outpatient visits per calendar year-combined in and out-of-network)	$25 copay per visit	50% coinsurance after deductible
Inpatient Care* (Up to 30 inpatient days per calendar year-combined in and out-of-network)	100% coverage	50% coinsurance after deductible (Acute Care general hospital only)
Alcohol/Substance Abuse		
Outpatient Visits in Office or Facility (Up to 60 outpatient visits per calendar year)	100% coverage	50% coinsurance after deductible
Inpatient Detoxification* (Up to 7 days detox per calendar year)	100% coverage	50% coinsurance after deductible (Acute Care general hospital only)
Inpatient Rehabilitation* (Up to 30 days per calendar year)	100% coverage	50% coinsurance after deductible (Acute Care general hospital only)
*You are responsible for seeing that CIGNA Behavioral pre-certifies all inpatient care. To request pre-certification, you must call CIGNA Behavioral prior to admission or within 48 hours of an emergency admission. If inpatient care is not pre-certified by CIGNA Behavioral, your benefits may be reduced or denied entirely.		

This chart details your coverage and copayments. In-network services are those provided by professionals within the CIGNA Behavioral Health network. Out-of-network services are those provided by professionals outside the network.

About Paperwork

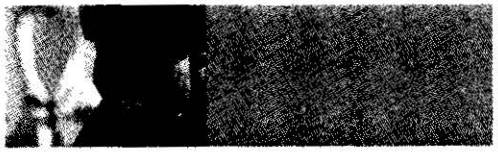
If you go to a provider within the CIGNA Behavioral Health network, we handle all the paperwork and claim forms. If you opt for an out-of-network provider, you will need to file a claim. To submit an out-of-network claim, send to:

CIGNA Behavioral Health
P.O. Box 46270
Eden Prairie, MN 55344

You will also be required to pay a larger portion of the costs yourself. Payment of out-of-network claims is based upon CIGNA's determination of the usual, customary and reasonable charge. Call 1-888-325-3986 if you have claim questions or to receive a claim form.

About Confidentiality

Everything you discuss with your counselor will be held in strict confidence, according to state and federal laws. Your employer is not notified of your visits, nor given specific information about your case without your written permission.



Your Behavioral Health Benefits as of: 1/1/08

Your Member Assistance Program (MAP) helps you balance work with family needs, deal with personal problems, and improve your overall performance and quality of life. Your MAP includes:

- Free consultations by telephone or up to 8 in-person sessions for behavioral health issues
- Information and referrals for child care, elder care, adoption, and more
- Immediate assistance for critical emotional needs
- Guidance for finding local resources

These services can be accessed 24-hours a day, 7-days a week, at www.cignabehavioral.com, or by calling toll-free at 1-888-325-3986.

No pre-authorization is required for routine outpatient care. In-network providers can also be found in our online provider directory at www.cignabehavioral.com.

Life can be challenging and stressful.
Everyone needs support from time to time.

Go Online:
www.cignabehavioral.com

or call us

1-888-325-3986

CIGNA Behavioral Health

Life can be challenging and stressful.
Everyone needs support from time to time.

Go Online:
www.cignabehavioral.com

or call us

1-888-325-3986

CIGNA Behavioral Health

NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

UNION TRUSTEES
Michael J. Forde
Chairman
Peter Thomassen
Denis Sheil III
Vincent Alcngi
Lawrence D'Errico
John E. Greaney

MANAGEMENT TRUSTEES
Richard Harding
Co-Chairman
George Greco
Michael Mazzucca
David Meberg
Paul O'Brien
Joseph Olivieri

January 16, 2004

IMPORTANT INFORMATION CONCERNING YOUR MEDICAL BENEFITS

Dear Participant:

Enclosed please find your new Empire BlueCross BlueShield (Empire) identification card(s). Present this card to your doctor or to the hospital when you receive hospital and medical care on and after February 1, 2004.

Why is Empire issuing new identification cards ?

The Welfare Fund has elected to change its hospital and medical provider network from Empire's Preferred Provider Organization (PPO) to Empire's Exclusive Provider Organization (EPO).

Why is the Welfare Fund changing from a PPO to an EPO ?

The Board of Trustees wants to maintain the high level of benefits you've come to expect. In order to do so, the Trustees need to contain costs wherever possible. Empire negotiates discounts for all of the services provided by the doctors and hospitals in their networks. These discounts mean that when you receive care from an in-network (or *participating*) provider, the Welfare Fund pays less than the usual amount charged by healthcare providers. When you receive care from an in-network provider, your out-of-pocket expense, if any, is limited to a small copayment. Perhaps just as important, you help the Welfare Fund contain costs when you receive care from in-network providers.

Many of the doctors and hospitals who participate in Empire's PPO network also participate in their EPO network. Empire has negotiated even deeper discounts with the hospitals and physicians in their EPO network. When you receive care from a provider who participates in both the PPO and the EPO networks, the Welfare Fund will receive the greater EPO discount. Your out-of-pocket expense will remain the same and, at the same time, the Welfare Fund will save valuable health care dollars.

I like my PPO doctor. Do I have to find a new doctor – one who participates in the Empire's EPO ?

No, you will continue to have the same access to all of the doctors and hospitals who participate in Empire's PPO network. As noted above, many of the providers who participate in Empire's PPO network also participate in Empire's EPO network. If your doctor or hospital does not belong to the EPO, you will receive the same in-network benefit as long as your provider continues to participate in Empire's PPO network.

Are my hospital and medical benefits changing ?

No, your in-network and out-of-network benefits and coverage remain the same. Same in-network copayments, same out-of network deductibles and coinsurance !

There is one important administrative change you do need to know about. If you use out-of-network healthcare providers on and after February 1, 2004, your out-of-network claims will not be processed by Empire. The Welfare Fund will continue to provide the same out-of-network coverage that was provided prior to February 1, 2004, however, in order to receive the deeper EPO discounts noted above, the Welfare Fund needs to take out-of-network claims processing away from Empire.

After careful consideration and review, the Board of Trustees has retained **C & R Consulting, Inc.** to process claims for out-of-network providers incurred on and after February 1, 2004.

C & R Consulting, Inc. has successfully administered the Welfare Fund's Medicare Part A and Part B Supplemental benefits program since January 1, 2003.

Where do I submit my out-of-network claim ?

If you incur expenses with an out-of-network medical provider after January 31, 2004, submit your claim to:

C & R Consulting, Inc
1501 Broadway
Suite 1724
New York, NY 10036

Tell your out-of-network medical provider to keep this information about C & R Consulting, Inc. on file for future reference.

You can contact C & R Consulting, Inc. by calling **(866) 320-3807.**

Claims for out-of-network expenses incurred prior to February 1, 2004 should continue to be submitted to Empire.

How do I know if my provider is in-network or out-of-network ?

In any non-emergency situation, it's always a good idea to ask your provider before any services are rendered whether or not they are participating Empire providers.

If you have access to the internet, you can visit Empire's website at www.empireblue.com. You can search for providers by name, address, language spoken, specialty and hospital affiliation.

To request a participating provider directory or to check the status of your provider, call Empire at 1-800-553-9603.

I'm scheduled to receive care at a hospital. What should I do ?

Since it's unusual when a hospital doesn't participate with Empire or with your local BlueCross BlueShield plan, hospital charges should be submitted to Empire or to the local plan. In most cases, you will not need to file a claim; the hospital will do it for you.

If surgery is performed in a network hospital, you will receive in-network benefits for the anesthesiologist whether or not the anesthesiologist is in Empire's network. Therefore, please be sure to submit all anesthesia claims to Empire or to the local BlueCross BlueShield plan.

Remember to call Empire's Medical Management Program at 1-800-553-9603 at least two weeks prior to any planned surgery or hospital admission. By calling Medical Management prior to your hospital admission, you'll be assured that your hospital is in-network and that your stay will be covered in full.

For an emergency admission or emergency surgical procedure, you or a family member should call Medical Management within 48 hours or as soon as reasonably possible.

Benefit reductions apply to all care related to the admission, including physician services, if your admission or surgery is not precertified by Medical Management.

What about out-of-network deductibles and coinsurance ?

Your out-of-network coverage requires that you satisfy a deductible before any payment is made. There is also a family deductible. Once you meet your deductible, the Welfare Fund pays a percentage of the remaining balance and you pay a percentage of the remaining balance. We call the percentage that you're required to pay *coinsurance.* You can find more information about your deductible and coinsurance amounts in your Summary Plan Description. Please bear in mind that the deductible and coinsurance apply to out-of-network claims only. The fee you pay when you use an in-network provider is called the *copayment.*

Out-of-network deductible and coinsurance amounts are calculated on a calendar year basis. Since we're changing the out-of-network claims administrator after the start of a new calendar year, you may meet all or part of your deductible with expenses incurred prior to February 1, 2004 (Empire). If you only satisfy part of your deductible, you'll have to satisfy the amount that remains with expenses incurred after January 31, 2004 (C & R).

Empire will provide information to C & R on any out-of-network deductible and coinsurance amounts credited to you for 2004. However, there's always going to be a lag between the time expenses are incurred, when claims are reported and when Empire provides the information to C & R.

We strongly suggest that you attach the Empire Explanation of Benefits (EOB) statement showing you met all or part of your 2004 out-of-network deductible to any claim you submit to C & R for expenses incurred after January 31. This will enable C & R to process your claim correctly.

Is there anything else I need to know ?

You still have the same out-of-network coverage and benefits you had previously. Only the out-of-network claims administrator is changing !

Behavioral health care claims, both in-network and out-of-network, are still administered by CIGNA.

You should retain this notice for future reference. This notice constitutes a summary of material modifications.

Keep these important phone numbers handy in case we haven't answered all of your questions:

Empire (800) 553-9603 for in-network hospital and medical claims and benefits

C & R Consulting (866) 320-3807 for out-of-network medical claims and benefits

CIGNA (888) 325-3986 for all behavioral health care claims

Fund office (800) 529-3863 for all health and welfare related issues

Sincerely,

BOARD OF TRUSTEES

New York District Council of Carpenters

BENEFIT FUNDS

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

Summary of Material Reductions to the New York City District Council of Carpenters Welfare Fund

This notice contains important information concerning your Welfare Fund benefits.

DATE: June 1, 2006

TO: All active participants of the New York City District Council of Carpenters Welfare Fund and their covered dependents
All covered retirees and their covered dependents
All covered surviving dependents
All COBRA participants

FROM: Board of Trustees of the New York City District Council of Carpenters Welfare Fund

This Summary of Material Reductions (SMR) describes changes to your benefits under the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund") recently adopted by the Welfare Fund's Board of Trustees (the "Trustees"). This SMR only describes recent changes to your benefits under the Welfare Fund, you must read this SMR together with your April 1, 2003 Summary Plan Description (SPD) for a full description of the terms and conditions governing your eligibility for benefits under the Welfare Fund. Please retain this SMR with your SPD. You may want to mark your SPD on the pages where this SMR has modified the SPD. The page references below refer to the April 1, 2003 SPD.

If you have any questions regarding this SMR or the Welfare Fund, or if you need another copy of the SPD, please call the Fund Office at (800) 529-3863 or write the Fund Office at New York City District Council of Carpenters Welfare Fund; 395 Hudson Street, New York, NY 10014.

A. **NEW RETIREE ELIGIBILITY RULES: EFFECTIVE FOR PARTICIPANTS RETIRING ON OR AFTER AUGUST 1, 2006.** The following sub-section describes changes to the eligibility rules governing when a participant may receive retiree coverage. The sub-section is effective for participants retiring on or after August 1, 2006, even if a participant is eligible to retire before August 1, 2006, but delays his/her retirement until August 1, 2006 or later.

Retirements that are effective on July 1, 2006 will use the current rules to determine eligibility for Retiree Health coverage. Please note, in order for you to retire effective July 1, 2006, your pension application must be received at the Fund Office no later than June 30, 2006.

(The following sub-sections will replace the sub-sections entitled "Eligibility for Retirees" and "Disability Pensioners," of the SPD.)

When you retire, any remaining hours in your bank are used to continue your coverage as an Active Employee. In order for Welfare Fund coverage to continue after your bank hours are used, you must qualify for Retiree health coverage.

You do not "bank" hours if you work in Covered Employment while you are retired. Therefore, you will not re-qualify for coverage as an Active Employee once you are eligible as a Retiree, even if you work 250 hours in Covered Employment.

In order to be eligible for Health and Welfare Coverage as a Retiree, your employer or employers must have contributed to the Fund for you as an Active Employee, and you must satisfy one of the three requirements below:

- You are at least 55 years old, and have earned at least 30 Vesting Credits with the New York City District Council of Carpenters Pension Fund (the "Pension Fund"). In general, you earn one Vesting Credit for each calendar year in which you work 870 hours or more in Covered Employment;

- You are at least 55 years old, have earned at least 20 Vesting Credits under the Pension Fund and, during the 60-month period immediately preceding the effective date of your pension, you are eligible as an Active Employee for at least 24 months; or

- You are at least 55 years old, have 25 years with at least 250 hours worked in Covered Employment, have earned at least 15 Vesting Credits under the Pension Fund and during the 60-month period immediately preceding the effective date of your pension, you are eligible as an Active Employee for at least 24 months.

Return to work. If you return to Covered Employment and your pension is suspended, your Retiree health coverage will continue for up to six months as long as you work at least 40 hours in each month. (Note that a special rule for disability pensions is discussed in the following section.)

Disability Pensioners

A Disability Pensioner who is an eligible Active Employee when disability commences will continue to be covered as described in the section entitled, "Continued Eligibility During Periods of Disability." (Please refer to the subsection called "Continuation of Coverage during Total Disability.)

If you are not eligible for Welfare Fund coverage as an Active Employee when disability commences, you will be eligible for Retiree health coverage as a Disability Pensioner provided that you satisfy one of the three rules in the preceding "Eligibility for Retirees" section, except for the age requirements.

Disability Pensioners who are eligible for, and in receipt of, a Social Security Disability Award should review the section entitled "Medicare" in the SPD.

B. **NEW IN-NETWORK HOSPITAL/MEDICAL COPAYMENTS: EFFECTIVE AS OF AUGUST 1, 2006.** New in-network copayments will be in effect for Active Employees, Retirees and dependents who are eligible for the hospital/medical benefits program administered by Empire BlueCross BlueShield. The new copayments do not apply to Retirees and dependents of Retirees who have Medicare as their primary source of coverage. The information that follows replaces information in the chart entitled " Hospital and Medical Benefits for Active Employees and their Dependents" and the chart entitled "Hospital and Medical Benefits for Retirees Who Are Not Medicare Eligible and Non-Medicare Eligible Dependents of Retirees and their Dependents" of the SPD.

1. ***New Copayment Amount for Certain In-Network Office Visits.*** For certain In-Network office visits, effective as of August 1, 2006, the new copay amount is $20 per visit. The $20 copay is applicable for services an individual receives in the offices of the following in-network practitioners:
   - Primary Care Physician,
   - Obstetricians,
   - Gynecologists,
   - Certified nurse midwives,
   - Chiropractors, and
   - Physical therapists.

2. ***New Copayment Amount for In-Network Specialist Visits.*** For In-Network Specialist visits, the new copay amount is $25 per visit. The $25 copay will apply for all in-network doctors not listed above when a copay is required.

3. ***New Copayment Amount for Services Received in Outpatient Facilities.*** For services received in an in-network, outpatient facility for physical, speech, language, occupational and vision therapies, and for cardiac rehabilitation, the new copay amount is $25 per visit.

4. ***New Copayment Amount for Emergency Care.*** For In-Network or Out-of-Network Emergency Room Visits, the new copay is $50 per visit.

Additional details about the new in-network hospital/medical co-pay amounts and new Empire BlueCross BlueShield identification cards, reflecting these changes, will be mailed to you prior to August 1, 2006.

C. **CHANGES TO PRESCRIPTION DRUG BENEFITS FOR ACTIVE AND RETIRED PARTICIPANTS AND THEIR DEPENDENTS: EFFECTIVE AS OF SEPTEMBER 1, 2006.** (This section revises the information in the section entitled "Prescription Drug Program," as described below.)

1. The Trustees have changed the Welfare Fund's prescription benefits manager from Caremark to MEDCO. Thus, prescription drug benefits will be administered by MEDCO. **Your new prescription cards along with more detailed information about these changes will be mailed to you at a later date. These new cards are effective September 1, 2006.** ***You can continue to use your old cards through August 31, 2006.***

2. New copayment amounts for prescriptions filled at a retail pharmacy (up to a 34 day supply):

	Co-Pay Per Prescription
Generic	$10
Preferred Brand Name Prescriptions*	$20
Non-Preferred Brand Name Prescriptions	$35

* *A Preferred Brand Name Prescription refers to a medication which is "Preferred" under the Welfare Fund. As described above and below, a higher copay will be required for a medication which is considered "Non-Preferred." For example, Lipitor, Zocor and Pravachol all treat cholesterol. However, one or more of these drugs may be considered "Non-Preferred" under the Welfare Fund, and you will be required to pay a higher co-pay (as described above and below) for a prescription of the drug. You can begin calling MEDCO directly at 1-800-939-2091 on September 1, 2006 to find out if a drug that you are taking is considered "Preferred." You can also visit MEDCO's website at www.medco.com*

3. New copayment amounts for prescriptions filled through the Welfare Fund's mail order program with Medco (up to a 90 day supply):

	Co-Pay Per Prescription
Generic	$20
Preferred Brand Name Prescriptions	$40
Non-Preferred Brand Name Prescriptions	$70

Using the mail order program saves you money because for the value of two retail copayments you get three months of drugs.

4. **If you are taking a "maintenance" drug you must use the mail order program under certain circumstances.** After your second refill of a maintenance drug prescription, you may not fill the prescription through a retail pharmacy, but must use the mail order program to fill the prescription. Maintenance drugs generally include drugs which treat chronic conditions such as high blood pressure or diabetes. ***You can begin calling MEDCO directly at 1-800-939-2091 on September 1, 2006 to find out if a drug that you are taking is considered a maintenance prescription drug. You can also visit MEDCO's website at www.medco.com***

Additional details and new prescription drug identification cards will be sent to you in future mailings prior to September 1, 2006.

SUMMARY OF NEW COPAYMENTS:

A. Co-Payments for In-Network Hospital/Medical Services:

Effective August 1, 2006

These new In-Network Hospital/Medical Co-pays do not apply to Retirees and dependents of Retirees who have Medicare as their primary source of coverage.)

Charge	Co-Pay Per Visit
In-Network Office Primary Care	$20
In-Network Office Specialist Visits	$25
Services Received in Outpatient Facilities	$25
Emergency Care	$50

B. Co-Payments for Prescriptions Filled at a Retail Pharmacy (up to a 34-day supply):

Effective September 1, 2006

Charge	Co-Pay Per Prescription
Generic	$10
Preferred Brand Name Prescriptions	$20
Non-Preferred Brand Name Prescriptions	$35

C. Co-payments for Prescriptions Filled through the Welfare Fund's mail order program with MEDCO (up to a 90-day supply):

Effective September 1, 2006

Charge	Co-Pay Per Prescription
Generic	$20
Preferred Brand Name Prescriptions	$40
Non-Preferred Brand Name Prescriptions	$70

Again, please retain this SMR with your SPD. The two documents should be read together for an accurate description of your current Welfare Fund benefits. For ease of your review, the following page summarizes the new copayments, and their effective dates. If you have any questions, please contact the Fund office at 1-800-529-3863.

ERISA Information
Plan Sponsor: Board of Trustees of the New York City District Council of Carpenters Welfare Fund
Address: New York City District Council of Carpenters Welfare Fund, 395 Hudson Street New York, NY 10014. Telephone: (212) 366-7300 or (800) 529-3863.
Sponsor's EIN Number: 13-5615576
Plan Number: 501
Plan Year: July 1 to June 30

NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

UNION TRUSTEES
Michael J. Forde
Chairman
Peter Thomassen
Denis Sheil
Lawrence D'Errico
John E. Greaney
Charles Harkin

MANAGEMENT TRUSTEES
David T. Meberg
Co-Chairman
George Greco
Richard Harding
Paul O'Brien
Kevin M. O'Callaghan
Joseph Olivieri

IMPORTANT NOTICE

Change to the New York City District Council of Carpenters Welfare Fund
Summary of Material Reductions dated June 1, 2006

DATE: **June 20, 2006**

TO: **All participants with at least 15 Vesting Credits in the New York City District Council of Carpenters Pension Fund who are or will be 55 years of age before August 1, 2006**

FROM: **Board of Trustees of the New York City District Council of Carpenters Welfare Fund**

The Summary of Material Reductions (SMR) dated June 1, 2006 describes changes to the Retiree eligibility rules that were to become effective for participants retiring on and after August 1, 2006. In an effort to provide participants who may be currently eligible to retire with additional time to consider such a life-event decision, **the Board of Trustees has changed the effective date of the new Retiree eligibility rule so that it is effective for participants retiring on and after September 1, 2006.**

Retirements that are effective on July 1, 2006 and retirements that are effective on August 1, 2006 will use the current rules to determine eligibility for Retiree Health coverage.

In order to secure a retirement effective date before September 1, 2006, your application for pension must be received at the Fund office before August 1, 2006.

If you have any questions regarding this notice, or if you need another copy of the SMR or the Summary Plan Description, please call the Fund Office at (800) 529-3863 or write to the Fund office at:

New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014.

You can also review these documents by visiting our website at www.nyccbf.com

Empire BlueCross BlueShield

EPO

Benefits Summary

New York City District Council of Carpenters Welfare Fund

Benefit	In-Network
Lifetime Maximum	Unlimited
Dependent Children	To age 19 ; full-time students to age 25
Home/Office/Outpatient Care	**Member Pays[1]**
Home/Office Visits	$20/$25 copay
Annual Physical Exam	$20/$25 copay
Well-Child Care (Up to age 19; including covered immunizations)	$0
Well-Woman Care	$20/$25 copay
Emergency Room/Facility (initial visit per occurrence)	$50 copay (Waived if admitted within 24 hours)
Surgery[2], Pre-surgical Testing, Anesthesia	$0
Chemotherapy, Radiation Therapy	$0
Maternity Care[2]	$0
Mammograms	$0
Cervical Cancer Screenings	$0
Laboratory Tests, X-rays	$0
MR[2]/MRA[2], CAT Scan, PET & Nuclear Cardiology	$0
Allergy Testing & Treatment	$20/$25 copay (Waived for treatment)
Chiropractic Care	$20 copay
Home Healthcare[2] (Up to 200 visits per calendar year)	$0
Home Infusion Therapy[2]	$0
Hospice Care[2] (Up to 210 days per lifetime)	$0
Physical Therapy[2] (Up to 45 visits per calendar year combined in home, office or outpatient facility)	$20 copay (in office setting) $25 copay (outpatient hospital setting)
Other Short-Term Rehabilitative Therapies[2] – Speech/Language, Occupational, Vision (Up to 45 visits per calendar year combined in home, office or outpatient facility)	$25 copay
Cardiac Rehabilitation[2]	$25 copay
Second and third surgical opinions and second and third opinions for cancer diagnosis[2]	$20/$25 copay (unless waived by Medical Management)
Kidney Dialysis	$0

(1) The following practitioners receive the lower (primary) copay for services provided in an office: obstetrician, gynecologist, certified nurse midwife, family practice, internal medicine, general practice, nurse practitioner, chiropractor and physical therapist (in office setting only). The higher (specialist) copay will apply for all other specialists when a copay is required, and for services received in an outpatient facility for physical, speech, language, occupational and vision therapies and for cardiac rehabilitation. A network provider must deliver all care. Empire does not provide out-of-network coverage. Claims for out-of-network providers must be submitted to the New York City District Council of Carpenters Welfare Fund, 1501 Broadway, Suite 1724, New York, NY 10036.

(2) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers. The BlueCard® PPO provider may call for you for services that do require precertification, but you will be responsible for penalties applied if precertification is not obtained.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Empire's Medical Management Program requirements could result in benefit reductions and, in some cases, a complete denial of coverage.

Benefit	In-Network
Inpatient Care[2]	**Member Pays[1]**
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0
Surgery, Surgical Assistant, Anesthesia	$0
Physical Therapy, Physical Medicine or Rehabilitation (Up to 30 inpatient days per calendar year)	$0
Skilled Nursing Facility (Up to 60 days per calendar year)	$0
Other	
Medical Supplies	$0
Durable Medical Equipment[2]	$0
Prosthetics & Orthotics[2]	$0
Ambulance (ground ambulance)	$0

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Empire's Medical Management Program requirements could result in benefit reductions and, in some cases, a complete denial of coverage.

EPO BCBS Rev Dec 05 *Prepared on 7/10/06 lh*

Empire BlueCross BlueShield

August 1, 2006

Important information about your Empire BlueCross BlueShield co-payments

Dear Member:

You have already been informed by the New York City District Council of Carpenters Welfare Fund (the "Fund") about the new in-network hospital and medical co-payments required for services provided on and after August 1, 2006. Enclosed you will now find a new Empire BlueCross BlueShield Benefits Summary that provides details about your in-network hospital and medical benefits, including the new co-payments. Please be sure to read it and keep it with your other health plan materials for future reference.

This letter also includes important information regarding precertification procedures. Please read it carefully so that you can receive your full Fund benefits when you seek treatment from a participating hospital or from a participating doctor.

In addition, we have enclosed your new member identification (ID) cards that list your new co-payment amounts. Please cut up your old card and replace it with this new one.

The new in-network hospital and medical co-payments that become effective August 1, 2006 are summarized below:

- The co-payment amount for treatment in a hospital emergency room is $50.
- The co-payment amount for certain in-network office visits is $20.* The $20 co-payment applies to the following types of providers:
  - Obstetrician/gynecologist
  - Certified nurse midwife
  - Pediatrician
  - Family Practice
  - Internal Medicine
  - General Practice
  - Nurse Practitioner
  - Chiropractors
  - Physical therapists (in-office setting only)

- The co-payment amount for an office visit with an in-network specialist is $25.*
  - A $25 co-payment is required for an office visit with any type of provider *except* those listed above.
  - In-network specialists requiring a $25 co-payment include those providing services for speech, occupational, vision or language therapies in both office and outpatient hospital settings. A $25 co-payment is also required for physical therapy when provided in a hospital outpatient setting).

We would also like to take this opportunity to remind you that precertification is required for certain services.

Precertification lets you and your doctor find out what services the Fund will cover. This process can help you both identify treatments and the proper setting for your care – for example, a hospital, an outpatient facility or your home. Empire has a special department that handles precertifications called the Medical Management Department.

Please consult your summary plan description (SPD) for a full listing of the services for which you must receive precertification in order for the Fund to cover the service.

All of the services listed below require precertification:

- All inpatient hospitalization and care in other facilities, such as a skilled nursing facility, an ambulatory surgery center, a rehabilitation center, a birthing center or a hospice. (You must call the Medical Management Department before any non-emergency admission and within 48 hours of an emergency admission.)
- Surgery in a hospital's ambulatory care or outpatient department.
- Second or third surgical opinions.
- Second or third opinions for cancer diagnosis.
- Prenatal and postnatal care. (You must precertify within three months of the beginning of the pregnancy and again within 24 hours after delivery.)
- Cosmetic surgery or reconstructive surgery.
- Cardiac rehabilitation.
- Ophthalmological or eye-related surgery.
- Outpatient transplants.
- Physical therapy and rehabilitation.
- Speech, occupational, vision or language therapy.
- MRIs/MRAs.
- Durable medical equipment.
- Prosthetics.
- Home healthcare.
- Inpatient and outpatient treatment for mental health and alcohol and substance abuse *not* administered by Empire. (For these types of treatments, please call CIGNA Behavioral Health at **1-888-325-3986**, available 24/7.)

When a physician determines that one of the above-listed services is necessary for your care, a call must be made to the Medical Management Department for precertification ***before you receive these services.***
If you fail to precertify, your benefits may be reduced or denied entirely. Your primary care physician, the specialist performing the procedure or the vendor providing the service may make the call and precertify the services for you, however, ***you will be responsible for any penalties that may arise if precertification is not obtained. Furthermore, your physician's verbal or written statement to you that the service has been precertified, or that precertification is not required, will not be a defense in the event that it is determined that you failed to precertify.***

To contact Empire's Medical Management Department call **1-800-553-9603**, Monday – Friday, 9:00 a.m. -5:00 p.m. For more information, please refer to your SPD.

For more information regarding your health plan benefits as well as the programs and tools available to you, register or log in to Member Online Services at ***www.empireblue.com*** or call the toll-free number on the back of your member ID card.

Empire BlueCross BlueShield is committed to helping you maintain and improve your health and will work with you and your doctors to be sure you always receive the care you need.

Sincerely,

Joanne Hogan
Vice President, Member Services

cc Benefit Summary
Member ID card

*Empire BlueCross BlueShield does not provide out-of-network coverage for the New York City District Council of Carpenters Welfare Fund. Claims for out-of-network providers must be submitted to: New York City District Council of Carpenters Welfare Fund, 1501 Broadway, Suite 1724, New York, NY 10036.

NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

TO: ***All participants and dependents eligible for Prescription Drug Benefits***

FROM: ***Trustees of the New York City District Council of Carpenters Welfare Fund***

SUBJECT: ***Changes to Prescription Drug Coverage***

DATE: ***May 3, 2007***

Please review this entire notice carefully and share it with your family. It is a summary of material modifications to the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund"). It describes changes to the prescription drug coverage provided by the Welfare Fund and updates the Summary Plan Description (employee booklet) that was previously distributed to you. You should keep this summary with your current employee booklet until the booklet is updated to reflect the changes discussed herein.

The changes described in Sections A and B below apply to <u>all</u> participants (i.e. actives and retirees) and dependents eligible for prescription drug benefits, and becomes effective on May 1, 2007. These changes form the basis of a clinical management program.

A. <u>Preauthorization for Prescription Drugs</u> - Effective May 1, 2007, you must obtain preauthorization from Medco in order to obtain coverage for certain prescription drugs. You can find the list of prescription drugs that require preauthorization on the table called ***"Prescription Drugs that Require Preauthorization"*** at the end of this notice. Generic forms of the prescription drugs listed also require preauthorization.

Your physician must call Medco at 1-800-753-2851 to initiate the preauthorization process for any of the prescription drugs listed.

Many of the prescription drugs that require preauthorization are considered "specialty medications". On the list of ***"Prescription Drugs that Require Preauthorization"***, an asterisk (*) following the name of a medication means that the prescription drug is considered a specialty medication. Specialty medications are used to treat complex medical conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis. Specialty medications are costly, have special storage requirements and often require specialized patient training and coordination of care.

You must obtain all specialty medications through Medco's specialty care pharmacy, Accredo Health Group. To reach Medco's specialty care pharmacy, you may call 1-800-803-2523. You can also provide your physician with your 12-digit Medco member identification number and ask him or her to call 1-800-987-4904.

Please be aware that both the list of ***"Prescription Drugs that Require Preauthorization"*** and those prescription drugs considered specialty medications are subject to change.

B. Coverage Limitations – For most prescription drugs, the Welfare Fund provides coverage in quantities up to a 34-day supply at retail pharmacies and up to a 90-day supply at the mail-order pharmacy. Effective May 1, 2007, however, coverage for certain prescription drug categories will have quantity limits and be subject to specific coverage requirements. If you choose to fill a prescription for more than the quantity limit or do not meet the specific coverage requirements, you will be responsible for the cost of the additional medication.

The prescription drug categories subject to separate quantity limitations and coverage requirements are listed in the table at the end of this notice called ***"Prescription Drugs with Quantity Limitations and Coverage Requirements"***. Generic forms of the prescription drugs listed are also subject to the same quantity limitations and coverage requirements.

These quantity limitations and coverage requirements are based upon United States Food and Drug Administration (the "FDA") approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

If special circumstances exist, your physician may request a review for additional coverage. As part of this review, your physician will be required to provide Medco with information supporting your need for additional coverage. Your physician can request a coverage review by calling Medco at 1-800-753-2851. Coverage reviews are available for all of the prescription drugs listed except where indicated on the ***"Prescription Drugs with Quantity Limitations and Coverage Requirements"*** table.

The change described in Section C below applies to all participants (i.e., actives and retirees) and dependents eligible for prescription drug benefits and is effective on June 1, 2007.

C. ***Additional Co-Payment for Brand-name Drugs with Generic Equivalents*** –Generic drugs are generally a safe, effective and less costly alternative to brand-name drugs. The FDA requires generic drugs to have the same quality, strength, purity and stability as brand-name drugs. Generic drugs save money for both you and the Welfare Fund.

Beginning June 1, 2007, when you purchase at a retail pharmacy a brand-name drug (either preferred or non-preferred) that has a generic equivalent, your co-payment will be the difference between the cost of the brand-name drug and the cost of the generic drug **plus** the usual $10 generic drug co-payment (rather than the usual brand-name drug co-payment of $20 for preferred brands and $35 for non-preferred brands). Since it is likely that the cost difference between the brand name drug and the generic drug will be substantial, when you purchase at a retail pharmacy a brand-name drug that has a generic equivalent you will pay more than the usual brand-name drug co-payments. Note that this change in the cost of brand-name drugs that have generic equivalents does not apply to brand-name drugs obtained from the mail-order pharmacy (only the usual brand-name drug co-payments apply).

The co-payment for brand-name drugs with generic equivalents purchased at retail pharmacies applies regardless of whether or not your physician writes the prescription as DAW (dispense as written). If your physician believes you must take the brand-name drug, he or she can request a coverage review by calling Medco at 1-800-753-2851.

The change described in Section D below applies only to retired participants (i.e., pensioners), surviving spouses, and individuals receiving Continuation of Coverage during Total Disability and their dependents who are eligible for prescription drug benefits provided by the Welfare Fund, and becomes effective on May 1, 2007.

D. <u>Prescription Drug Out-of-Pocket Maximum for Retirees</u> - Beginning May 1, 2007, the co-payments that each individual pays for covered prescription drugs will accumulate towards a $1,250 individual (i.e., per person)out-of-pocket annual maximum (subject to the exceptions and rules set forth below). Whenever the co-payments for an individual total $1,250 during a 12-month accumulation period, the Welfare Fund pays the full cost of all additional covered prescription drugs that the individual requires for the remainder of that same 12-month accumulation period (subject to the exceptions and rules set forth below).

The 12-month accumulation periods begin on May 1 of each year and will end on April 30 of the following year. Therefore, the first accumulation period runs from May 1, 2007 through April 30, 2008.

Accumulations toward the individual out-of-pocket maximum are re-set to $0 on May 1 of each year (the beginning of a new 12-month accumulation period). Co-payments are not carried over from previous 12-month accumulation periods under any circumstances.

Co-payments for prescription drugs obtained from retail pharmacies, from the mail-order pharmacy and from the specialty pharmacy (discussed in Section A above) are all added together to satisfy the $1,250 individual out-of-pocket maximum (subject to the exceptions and rules set forth below).

The following exceptions and rules apply to the individual out-of-pocket maximum:

i. Because of the current mandatory mail-order program for maintenance prescription drugs, when an individual uses a retail pharmacy to obtain a maintenance prescription drug after that same maintenance drug has been previously filled three times at a retail pharmacy, the co-payment or any other costs for such prescription does not accumulate towards the individual out-of-pocket maximum (only the co-payments for the first three fills for such maintenance prescription drug at a retail pharmacy will apply toward the individual out-of-pocket maximum). The cost of a maintenance drug prescription after the third fill at a retail pharmacy will not be covered by the Welfare Fund even after the individual out-of-pocket maximum has been reached.

ii. Beginning June 1, 2007 under the new rules for purchases at a retail pharmacy of brand-name drugs that have a generic equivalent (see Section C above), when an individual is required to pay a generic drug co-payment plus the difference in cost of the brand-name drug and a generic equivalent, both the generic drug co-payment and the cost differential apply towards the individual out-of-pocket maximum. Once you satisfy the individual out-of-pocket maximum, the generic drug co-payment applicable for the brand-name drug will be waived. However, you always remain responsible for the cost difference between the brand name and generic drug even if you have already satisfied the individual out-of-pocket maximum.

iii. Co-payments for prescription drugs that an individual pays while covered as an Active employee or under COBRA Continuation Coverage do not accumulate towards the $1,250 individual out-of-pocket maximum when an individual's status changes (for example, from Active to Retired) during a 12-month accumulation period.

This summary only highlights the key changes made to the New York City District Council of Carpenters Welfare Fund. Summaries of material modifications together with the Summary Plan Description make up your official plan descriptions; please keep them together and refer to them as necessary. We have made every attempt to ensure the accuracy of the information in this summary and the Summary Plan Description. However, if there is any discrepancy between them and the insurance contracts or other legal documents, the legal documents will always govern. If you need a copy of the Summary Plan Description, please call the Fund Office at (800) 529-3863 or write to the Fund Office at:

New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014

The plan sponsor of the New York City District Council of Carpenters Welfare Fund reserves the right to amend or terminate the New York City District Council of Carpenters Welfare Fund, or any part of it, at any time.

PRESCRIPTION DRUGS THAT REQUIRE PREAUTHORIZATION

Drug Category	Drug Names
Narcotic Analgesic	*Actiq®* *Fentora®*
Antiemetic Agents	*Zofran®* *Kytril®* *Anzemet®* *Cesamet®*
Rheumatoid Arthritis	*Enbrel®** *Kineret®** *Orencia®** *Humira®** *Rituxan®** *Remicade®** *Arava®*
Red Blood Cell Stimulants	*Procrit®** *Epogen®** *Aranesp®**
Anti Narcoleptic Agents	*Provigil®*
Platelet Stimulants	*Neulasta®** *Neumega®** *Neupogen®** *Leukine®**
Interferons	*Actimmune®** *Alferon-N®** *Infergon®** *Intron-A®** *Pegasys®** *Peg-Intron®** *Rebetron®** *Roferon®**
Immunomdulatory Agents	*Thalomid®** *Revlimid®**

* specialty medication

PRESCRIPTION DRUGS WITH QUANTITY LIMITATIONS AND COVERAGE REQUIREMENTS

Drug Category	Drug Names	Quantity Limitation or Coverage Requirement
Migraine Therapy	*Amerge®* *Axert®* *Frova®* *Imitrex®* *Maxalt®, Maxalt-MLT®* *Migranal®* *Zomig®, Zomig ZMT®* *Relpax®*	Retail – up to 4 treatment days per 30-day period Mail – up to 12 treatment days per 90-day period
Hypnotic Agents	*Ambien®, Ambien CR®* *Sonata®* *Lunesta®* *Rozerem®*	Retail & Mail – up to 60 days of treatment per 90-day period
COX-II Inhibitors	*Celebrex®*	Retail & Mail – coverage provided immediately if patient is over age 65 or if patient has an active prescription for any of the following: • *Celebrex®,* • a non-steroidal anti-inflammatory, • an anticoagulant, • an antiplatelet, or • an anti-ulcer medication.
Narcotic Analgesics	*Actiq®*	Retail – up to 120 units per 23-day period Mail – up to 360 units per 68-day period
	Fentora® 100 or 200 µg **(no coverage reviews)**	Retail – up to 120 units per 23-day period Mail – up to 360 units per 68-day period
	Fentora® 400, 600 or 800 µg	Retail – up to 240 units per 23-day period Mail – up to 720 units per 68-day period
Non-Narcotic Analgesics	*Ultram®* **(no coverage reviews)**	Retail & Mail – up to a 16-day Supply per 90-day period
	Ultracet® **(no coverage reviews)**	Retail & Mail – up to a 10-day supply per 90-day period

NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

TO: ***All participants and dependents eligible for Welfare Fund benefits***

FROM: ***Trustees of the New York City District Council of Carpenters Welfare Fund***

SUBJECT: ***Changes to Kidney Dialysis, Chiropractic and Prescription Drug Coverage***

DATE: ***September 14, 2007***

Please review this entire notice carefully and share it with your family. It is a summary of material modifications to the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund"). It describes changes to the hospital/medical and prescription drug coverage provided by the Welfare Fund and updates the Summary Plan Description (employee booklet) that was previously distributed to you. You should keep this summary with your current employee booklet until the booklet is updated to reflect the changes discussed herein.

The changes described in Sections A, B and C below apply to all participants (i.e. actives and retirees) and dependents eligible for hospital/medical benefits provided by Empire BlueCross BlueShield. SECTIONS A, B AND C DO NOT APPLY TO ANY PARTICIPANT OR DEPENDENT FOR WHOM MEDICARE PROVIDES PRIMARY COVERAGE.

A. Coverage for Kidney Dialysis and Chiropractic Services Limited to In-Network Providers Only

Effective October 1, 2007, coverage for kidney dialysis and chiropractic treatment will be limited to in-network providers only. (This change does not apply if your primary coverage is through Medicare). You can find in-network providers by calling Empire BlueCross BlueShield (Empire) at 1-800-553-9603 or by visiting Empire's website at www.empireblue.com.

If you are currently receiving kidney dialysis or chiropractic treatment from an out-of-network provider, a special transitional rule will apply. The transitional rule allows individuals who are currently receiving kidney dialysis or chiropractic treatment to continue receiving out-of-network coverage for treatment rendered during the period from October 1, 2007 through December 31, 2007. Under no circumstances will out-of-network coverage be provided for any kidney dialysis or chiropractic treatment rendered after December 31, 2007.

B. Precertification Required for Kidney Dialysis

Effective October 1, 2007, kidney dialysis treatment will be added to the list of services that require precertification from Empire's Medical Management Department before treatment begins. (This change does not apply if your primary coverage is through Medicare). You, your physician or the facility providing kidney dialysis treatment may call the Medical Management Department at 1-800-

553-9603. Please refer to your Summary Plan Description and previous summaries of material modifications for a full listing of the services for which you must obtain precertification.

If you do not obtain precertification before beginning kidney dialysis treatment, your benefits may be reduced or denied entirely. While your physician or the facility providing the service may call the Medical Management Department, you are ultimately responsible for any penalties that may arise if precertification is not obtained. Your physician's or the facility's verbal or written statement to you that the service has been precertified, or that precertification is not required, will not be a defense in the event it is determined that you failed to precertify.

Individuals who begin kidney dialysis treatment at an in-network facility prior to October 1, 2007 are not required to obtain precertification.

Individuals currently receiving kidney dialysis treatment with an out-of-network provider who switch to an in-network facility after September 30, 2007 are required to obtain precertification prior to changing but in no event later than December 31, 2007.

C. Calendar Year Visit Limitation for Chiropractic Treatment

Effective January 1, 2008, coverage for in-network chiropractic treatment will be limited to 45 visits per calendar year. (This change does not apply if your primary coverage is through Medicare). As explained above, there is no out of-network coverage for chiropractic treatment after October 1, 2007.

Although you are covered for up to 45 in-network chiropractic visits per calendar year, your Welfare Fund benefits only cover expenses for Medically Necessary care. Services, supplies or equipment are Medically Necessary if Empire determines that they are:

- consistent with the symptoms or diagnosis, and treatment of the patient's condition, illness or injury;
- appropriate with regard to standards of good medical practice;
- not solely for the patient's, family's or provider's convenience;
- not primarily custodial; and
- the most appropriate level of service for the patient's safety.

The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it Medically Necessary.

The change described in Section D below applies to all participants (i.e., actives and retirees) and dependents eligible for prescription drug benefits.

D. Coverage Limitation for Actiq® and Fentora™

Effective October 1, 2007, coverage for the prescription drugs Actiq® and Fentora™ will be limited to situations where these products are being prescribed for the management of breakthrough cancer pain, where the use of other oral immediate release narcotics have been tried to manage the patient's breakthrough cancer pain and where the patient is currently receiving and tolerant to a long-acting narcotic analgesic for treatment of their chronic pain.

Using the requirements above, coverage for Actiq® and Fentora™ will be determined through the preauthorization process that is already in place for these products. Your physician must call Medco at 1-800-753-2851 to initiate the preauthorization process for Actiq® and Fentora™.

Individuals who have received coverage for Actiq® and Fentora™ prior to October 1, 2007 and who are currently taking these products for conditions other than breakthrough cancer pain will continue to receive coverage until December 31, 2007. On and after January 1, 2008, the requirements above will apply to all participants.

This summary only highlights the key changes made to the New York City District Council of Carpenters Welfare Fund. Summaries of material modifications together with the Summary Plan Description make up your official plan descriptions; please keep them together and refer to them as necessary. We have made every attempt to ensure the accuracy of the information in this summary and the Summary Plan Description. However, if there is any discrepancy between them and the insurance contracts or other legal documents, the legal documents will always govern. If you need a copy of the Summary Plan Description, please call the Fund Office at (800) 529-3863 or write to the Fund Office at:

New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014

The plan sponsor of the New York City District Council of Carpenters Welfare Fund reserves the right to amend or terminate the New York City District Council of Carpenters Welfare Fund, or any part of it, at any time.

NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

SUMMARY OF MATERIAL MODIFICATIONS

TO: **All Participants and Dependents Eligible for Welfare Fund Dental Benefits**

FROM: **Trustees of the New York City District Council of Carpenters Welfare Fund**

SUBJECT: **New Dental Program Effective July 1, 2008**

DATE: **April 15, 2008**

This document is a Summary of Material Modifications ("Notice") intended to notify you of important changes made to the New York City District Council of Carpenters Welfare Plan (the "Welfare Plan"). You should take the time to read this Notice carefully and keep it with the copy of the Summary Plan Description ("SPD") that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding these changes to the Welfare Plan, please contact the Fund Office during normal business hours at 395 Hudson Street, New York, NY 10014, telephone number (800) 529-3863.

IMPORTANT NOTICE ABOUT YOUR DENTAL BENEFITS

The New York City District Council of Carpenters Welfare Fund's dental benefits program provides you with the option of going to any dentist or going to a participating or in-network dentist. You save money when you use participating or in-network dentists. Participating or in-network dentists agree to accept the Welfare Fund's Schedule of Covered Dental Allowances as payment-in-full for covered services. When you use a participating or an in-network dentist, your out-of-pocket expense for covered services, subject to Plan maximums and frequency limitations, is limited to the amount applied towards your $100 calendar year individual deductible. Many diagnostic and preventive services that are not subject to the deductible are covered in full by the Welfare Fund.

If you choose to go or if you must go to a non-participating or an out-of-network dentist, you or your dentist will be reimbursed according to the Plan's Schedule of Covered Dental Allowances. The charges of non-participating or out-of-network dentists may be higher than the Plan's

scheduled allowances. You are responsible for any difference between the amount your dentist charges and the amount the Plan pays.

Choose Your Own Network of Participating Dentists

Prior to July 1, 2008, the Welfare Fund only offered one dental administrator (ASO/SIDS). Beginning July 1, 2008, the Welfare Fund will offer three different dental administrators for you to choose from. Each administrator manages its own network of participating or in-network dentists. You get to choose the network of participating dentists that best suits you and your family. Each administrator's participating dentists agree to accept the Welfare Fund's Schedule of Covered Dental Allowances as payment in full for covered services.

During April and May 2008, all participants eligible for dental coverage from the Welfare Fund at any time during the first half of calendar year 2008 are being given the opportunity to select any one of the three dental benefits administrators listed below:

HEALTHPLEX **SELE-DENT, INC.** **ASO/SIDS**

After July 1, 2008, you must send all of your dental claims, whether old or new, to the administrator you have chosen. In order for dental expenses incurred on and after July 1, 2008 to be considered in-network, you must use a dentist or dentists that participate with or are in-network with the administrator you have selected.

Selecting a Dental Administrator

Review the booklet prepared by each of the three dental administrators. The booklet provides general information about the administrator and how it conducts its business. Most importantly, each booklet includes the administrator's list of participating dentists and specialists. You may want to check each list for your or for your family's dentist. If you do not have a family dentist, you may want to determine if the administrator has dentists or specialists near where you live.

Additional information may also be available on the administrator's web site. You can find an administrator's web site address in its booklet.

Each administrator will use the Welfare Fund's current Schedule of Covered Dental Allowances to pay claims. Dental benefits are the same regardless of which of the three administrators you select. The individual calendar year deductible, the annual dental benefit maximums, the frequency limitations and the covered dental services are the same for all three administrators. All three administrators will also process your claims for services that are provided by non-participating or out-of-network dentists. You will not receive a greater level of benefits by choosing one dental administrator over another.

The Fund office will not accept more than one Dental PPO Election Form from the same household. The administrator you select applies both to you and to all of your eligible

dependents. For example, you may not select one administrator for you and your spouse and a different administrator for your eligible dependent children. Therefore, it is very important for both you and your family to consider and make your selection carefully.

Informing the Welfare Fund of Your Selection

The last page of this Notice is labeled New York City District Council of Carpenters Welfare Fund Dental PPO Election Form. Each dental benefits administrator is listed on the form. Check or mark the box next to the dental administrator you are selecting and return the Election Form no later than June 1, 2008.

Please be sure to print your name and social security number or, if applicable, your UBC number in the spaces provided. You must also sign and date the election form where indicated. Return your completed Dental PPO Election form in the pre-addressed, postage paid envelope that is part of this package.

If you were eligible for dental benefits from the Welfare Fund at any time during the period from January 1, 2008 to June 30, 2008, the Fund office must receive your completed election form by June 1, 2008. If you do not return your completed election form to the Fund office by June 1, 2008, the processing of your dental claims may be delayed. In the event a participant eligible for dental benefits during the first half of calendar year 2008 does not return the election form to the Fund Office by June 1, 2008, the participant and all of the participant's eligible dependents will remain with the Welfare Fund's current administrator, ASO/SIDS, for the remainder of the calendar year. You may not change this assignment until the next open enrollment period.

Changing Dental Administrators

In general, there will be an open enrollment period during each Fall season for the following calendar year. Therefore, you will have another opportunity to select a dental administrator during Fall 2008. If you do decide to change administrators this Fall, the company you select will be your dental administrator for the period from January 1, 2009 through December 31, 2009.

If you do not select a new administrator during an open enrollment period, we will continue your dental coverage with the administrator you selected or were assigned to previously.

Participants Eligible For the First Time On and After July 1, 2008

Participants who were not eligible for Welfare Fund dental benefits during the period from January 1, 2008 through June 30, 2008 and who become eligible on and after July 1, 2008 must select a dental administrator before their dental coverage can be activated. This applies both to participants becoming eligible for the first time and to participants who may have been eligible prior to January 1, 2008.

The administrator selected by participants becoming eligible for the first time on and after July 1, 2008 will be that participant's dental administrator for the remainder of the calendar year. As explained in the preceding section, open enrollment will take place each Fall season for the following calendar year.

If You Have Questions

If you have any questions about your dental benefits or if you need another Dental PPO Election Form, please call the Fund Office at (800) 529-3863

This Notice is intended to provide you with an easy-to-understand description of certain changes to the Welfare Plan. While every effort has been made to make this description as complete and as accurate as possible, this Notice, of course, cannot contain a full restatement of the terms and provisions of the Welfare Plan. If any conflict should arise between this Notice and the Welfare Plan, or if any point is not discussed in this Notice or is only partially discussed, the terms of the Welfare Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Welfare Plan, or any benefits provided under the Plan, in whole or in part, at any time for any reason, in accordance with the applicable amendment procedures established under the Plan and the Amended Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make promises to you about benefits under the Welfare Plan, or to change any provision of the Welfare Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Welfare Plan and decide all matters arising under the Welfare Plan.

NEW YORK CITY DISTRICT COUNCIL OF CAREPNTERS WELFARE FUND

DENTAL PPO ELECTION FORM

July 1, 2008 – December 31, 2008

Please print clearly

Employee/Retiree Name: _____
Last First

Social Security Number: _____
or
UBC Number _____

Dental Benefit Options (check the company you want as your dental benefits administrator)

☐ **HEALTHPLEX**

☐ **SELE-DENT, INC.**

☐ **ASO/SIDS**

Employee/Retiree Certification

1. I have received, read, and understand the information explaining my Dental Benefit Options.

2. I request that the company I have elected on this form administer my Welfare Fund Dental Benefits and the Dental Benefits for all my eligible dependents.

3. I understand that by signing this form, I make a binding election concerning my Dental Benefits for the period specified above. I also understand that I will not be able to change my Dental Benefits administrator prior to the next open enrollment period.

4. I understand that if I do not submit another Dental PPO Election Form during subsequent open enrollment periods, this election will remain in effect.

Employee/Retiree Signature: _____ **Date:** _____

Please complete, sign and return this form to the Fund Office no later than June 1, 2008 using the pre-addressed, postage paid envelope. If you do not use the pre-addressed, postage paid envelope, please return the form to: New York City District Council of Carpenters Welfare Fund, 395 Hudson Street, New York, NY 10014, Attention: Dental PPO.

NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

UNION TRUSTEES
Frank G. Spencer
Co-Chairman
John Ballantyne
Lawrence D'Errico
Charles Harkin
Douglas J. McCarron

Stuart R. GraBois
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

MANAGEMENT TRUSTEES
Michael Weber
Co-Chairman
John A. Brunetti
George Greco
David T. Meberg
Paul O'Brien
Kevin O'Callaghan

Memorandum

TO: All Participants in the New York City District Council of Carpenters Welfare Fund including Active Employees, Retirees, Survivors and COBRA participants and all of their Eligible Dependents

FROM: Board of Trustees

DATE: June 8, 2011

RE: Health Care Reform: Required Notices, Summary of Material Modification and Age 26 Enrollment Notice

---

As you know, health care reform legislation was passed by Congress and signed into law by President Obama in March 2010. The name of the law is the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Although the law has been in existence for over a year now, many of its requirements did not become effective until the first plan year beginning on or after September 23, 2010 (six months after the date that the law was enacted). The New York City District Council of Carpenters Welfare Fund (the "Fund") has a plan year that begins July 1. Thus, some of the provisions of the law that apply to this Fund are becoming effective for the first time on July 1, 2011, and that is why you are receiving the enclosed documents at this time.

Following is a summary of the enclosed documents:

1. **Notice of Grandfathered Health Plan**: Because this Fund was in existence in March 2010 when the law was enacted, certain of the new requirements in the law do not apply to the Fund. In other words, the Fund is considered to be a "grandfathered plan." The first notice explains what it means to be a grandfathered plan.

2. **Notice about the Early Retiree Reinsurance Program**: The Affordable Care Act created a program for a limited reimbursement to health care plans, such as this Fund, for some of the health care costs they pay on behalf of retirees who are age 55 or older and are not yet eligible for Medicare. In order to participate in this federal reimbursement program, health plans have to comply with certain restrictions. The second notice describes those requirements.
3. **Notice of Enrollment Opportunities**: The Affordable Care Act requires health plans to provide coverage for adult dependent children up to age 26. It also prohibits a health plan from having lifetime limits on essential health benefits. The third notice describes the new enrollment opportunities for adult dependent children as well as for any individual who previously lost coverage as a result of having reached the Fund's lifetime limit of $1 million applicable to out-of-network benefits only.
4. **Description of Plan Changes**: This document describes the changes to the Fund in order for the Fund to comply with the Affordable Care Act. As described in the enclosure, the changes include an extension of coverage to adult dependent children (*see* #3 above), the elimination of the lifetime limit on out-of network benefits (*see* #3 above), and certain changes required by law to pediatric dental and vision benefits.
5. **Age 26 Adult Children Enrollment Form**: This is the form (and accompanying instructions) that must be submitted to the Fund by July 31, 2011 in order to enroll adult dependent children.

Please do not hesitate to contact the Fund Office if you have any questions.

Enclosures

Important Information Regarding Your Welfare Trust Fund Benefits

---

This document contains important information concerning your New York City District Council of Carpenters Welfare Fund benefits. Please read it and keep it with your Summary Plan Description (SPD) for future reference. Please share this document with your family.

I. Notices

Notice of Grandfathered Health Plan

The Board of Trustees believes the New York City District Council of Carpenters Welfare Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 212-366-7300 or toll free at: 800-529-3863. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notice About the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

NOTICES OF ENROLLMENT OPPORTUNITIES

Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Effective July 1, 2011, the Fund will extend coverage to participants' eligible children up to the end of the month in which the child reaches age 26. Coverage is available whether the child is married or unmarried, regardless of student status, employment status[99], financial dependency on the participant, or any other factor other than the relationship between the child and the participant. The Plan amendment pertaining to the new definition of Dependent Children is described in Section II of this announcement. If you have a child who is under age 26 (whether married or unmarried), including a child currently receiving continuation coverage under COBRA, that child may be eligible to enroll in the Plan as of July 1, 2011.

Individuals whose coverage ended, who were denied coverage, or who were not eligible for coverage, because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the NYC District Council of Carpenters Welfare Fund. If you wish to enroll your child for coverage beginning July 1, 2011, please complete the attached enrollment form and return it to the Fund Office by no later than July 31, 2011. If you request enrollment by that date, coverage will be effective on July 1, 2011. For more information, contact the Fund Office at the New York City District Council of Carpenters Welfare Fund, 395 Hudson Street, 8th Floor, New York, NY 10014; Phone: 212-366-7300 or toll free at: 800-529-3863; Fax: 212-366-3301.

Lifetime Limit No Longer Applies

The overall lifetime limit of $1,000,000 on the Out-of-Network Benefits under the New York City

District Council of Carpenters Welfare Fund no longer applies. Individuals whose coverage ended by reason of reaching this lifetime limit are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact the Fund Office. Please see Section II on Plan changes for information on annual limits now applicable for the Plan effective July 1, 2011.

---

[99] As explained later in this announcement, for plan years beginning prior to January 1, 2014, an adult Dependent Child is not eligible for coverage under the Plan if he/she is eligible for coverage under another employer-sponsored health plan other than a group health plan of a parent.

II. Plan Changes Effective July 1, 2011

The section of the SPD entitled "Dependent Coverage" is replaced in its entirety with the following:

Dependent Coverage

If you are covered, your eligible dependents may be covered for medical, dental, prescription drug, vision care, hearing aid and dependent life insurance benefits. Eligible dependents include your:

- **Lawful spouse**
- **Covered Child**, any of the Active Employee's or Retirees children listed below who are under the age of 26 (whether married or unmarried):
  - **Son or daughter** (proof of relationship and age will be required).
  - **Stepson or stepdaughter** (proof of relationship and age will be required).
  - **Legally adopted child or child placed for adoption** with you (proof of adoption or placement for adoption and age will be required), including children placed in your home by a licensed placement agency for the purpose of adoption or Children who have been living in your home as foster Children for whom foster care payments are being made, and petition for adoption has been filed. Your adopted newborn children, who are covered from the moment of birth (once the adoption becomes finalized), provided the proposed adoptive parent takes custody of the infant as soon as the infant is released from the hospital after birth and the parent files an adoption petition with New York State (or the state where you live) within 30 days of the infant's birth. However, adopted newborns will not be covered from the moment of birth if (1) one of the child's birth parents covers the newborn's initial hospital stay; (2) a notice revoking the adoption has been filed; or (3) one of the birth parents revokes their consent to the adoption. The child's placement for adoption terminates upon the termination of such legal obligation.
  - A child named as an "alternate recipient" under a **Qualified Medical Child Support Order.**
  - **Unmarried Disabled Children age 26 and over** (Children incapable of self-sustaining employment) who are primarily dependent upon you for support and maintenance, provided:
    - such Children depend on you for more than one half of their annual financial support;
    - such Children live with you in the same principal residence for more than half the calendar year except for temporary absences due to special circumstances such as education, Illness, or if such Children reside in a treatment center; and
    - such incapacity commenced while the child was covered by the Welfare Fund; and
    - you provide the required proof of the incapacity to the Fund Office within 12 months of the date the child's coverage would have otherwise ended. (The Trustees reserve the right to have such eligible dependent examined by a doctor of their choice to determine the existence of such incapacity)
  - **Dependent parents** (if you are not married and have no eligible dependent Children, you may cover a parent(s) who lives in the United States and is claimed as a dependent on your federal income tax return for the preceding year).

Except for disabled children described above, coverage for the Covered Children generally continues until the end of the month in which they reach age 26. Coverage for a Covered Child who is disabled prior to reaching the limiting age while covered under the Plan will terminate the earliest of the date the child: (1) is no longer disabled as defined by the Plan; (2) marries; (3) is no longer dependent on you (the Active Employee/Retiree) for support and maintenance; or (4) the date you are no longer covered under the Plan.

For plan years beginning prior to January 1, 2014, an adult Dependent Child is not eligible for coverage under the Plan if such adult child is eligible for coverage under another employer-sponsored health plan other than a group health plan of a parent.

When Coverage Ends

The "When Coverage Ends" section of the SPD is amended by the following at the end of the section:

Coverage for you and/or your dependents may be terminated retroactively (rescinded) due to any of the following:

- in cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30 day notice);
- due to non-payment of premiums (including COBRA premiums);

Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage (or, in the case of adult children, eligibility for other employer-sponsored coverage) constitutes intentional misrepresentation of material fact to the Plan.

Elimination of Lifetime Limit for Major Medical Expense Benefit Effective July 1, 2011

The Lifetime maximum of $1,000,000 under the Plan for out-of-network benefits is eliminated and replaced with an annual limit for out-of-network benefits for each covered individual of $1,000,000 for the July 1, 2011 to June 30, 2012 plan year.

Dental Benefits for Pediatric Services

Pediatric preventive and diagnostic services will be paid as medically necessary in accordance with the Fund's allowances for children under the age of 19 and will not be subject to the $2,500 annual maximum ($1,500 maximum for Retirees). All other Dental benefits will otherwise continue to be paid in accordance with the Plan's benefit schedule, and will continue to be subject to the annual maximums.

Optical Benefits for Pediatric Services

Pediatric vision benefits will be payable for one pair of glasses and one eye exam per 12 month period in accordance with the Plan's benefit schedule.

This summary only highlights the key changes made to the New York City District Council of Carpenters Welfare Fund. Summary of material modifications (SMMs) together with the Summary Plan Description make up your official plan descriptions; please keep them together and refer to them as necessary. We have made every attempt to ensure the accuracy of the information in this SMM and the SPD. However, if there is any discrepancy between them and the insurance certificates/Empire booklet or other legal documents, the legal documents will always govern.

If you would like to request a copy of the SPD, please contact the Fund Office.

Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, who were denied coverage, or who were not eligible for coverage because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the NYC District Council of Carpenters Welfare Fund. If you wish to request enrollment for your child, please complete the attached enrollment form and return it to the Fund Office by July 31, 2011. If the form is received by July 31, 2011, coverage will be effective July 1, 2011. If the form is received after July 31, 2011, coverage will not be effective until the first day of the month following the month in which the completed form is received. **In order for your child to be covered by the Welfare Fund, you (the Participant) must be an eligible Active Employee or an eligible Retiree in the Welfare Fund.** For more information, contact the Fund Office.

INSTRUCTIONS FOR REQUESTING ENROLLMENT FOR CHILD TO AGE 26

You must complete this form if you want to enroll:

- Children younger than age 26 who were not previously eligible to enroll in the Plan;
- Children younger than age 26 who were previously denied coverage under the Plan; and
- Children younger than age 26 whose coverage under the Plan previously ended.

You must complete a separate form for each child you wish to enroll in the Plan. You (the Participant) must complete the form in its entirety and you, your adult child, and your adult child's spouse (if applicable) must all sign and date the form. Your (the Participant) signature must be notarized.

Please note:

- If you have more than one child whom you wish to enroll, you will need to complete a separate form for each child.
- You must include a copy of each child's birth certificate.
- You must complete the attached form and return it to the Fund Office by **July 31, *2011***. If you do so, coverage for your adult child will be effective July 1, 2011 (or will continue past July 1, 2011).
- If the Fund Office does not receive this form by July 31, 2011, you will not be able to enroll a child during this special enrollment opportunity. If you enroll your dependent child after the July 31, 2011 deadline, coverage will not be effective until the first of the month after the date the Fund Office receives your completed enrollment materials.

For adopted children or those placed for adoption with you, please provide a copy of the adoption paperwork. For a stepchild, please provide a copy of your and your spouses' (the child's natural parent's) marriage certificate, as well as the child's birth certificate.

ENROLLMENT FORM FOR ELIGIBLE CHILDREN TO AGE 26

Complete one form for each Child

YOU MUST SIGN THE BACK OF THIS FORM AND HAVE IT NOTARIZED FOR THE FORM TO BE ACCEPTABLE TO THE FUND OFFICE.

A. Participant (Employee/Retiree) Information:			
Last Name		First Name	Middle Initial (MI)
Mailing Address			Social Security Number
City		State	Zip Code
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Home Phone Number	Cell Phone Number

B. Child Enrollment: Child's relationship to you:
☐ Son/Daughter ☐ Stepchild ☐ Adopted child ☐ Child placed with you for adoption ☐ Foster Child

Child's Last Name		First Name	Middle Initial (MI)
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Child's Social Security Number	

Is your adult child (age 19 to 26) :	Is your adult child ***Eligible for*** other employer-sponsored coverage:
• Currently enrolled in the Plan: ☐ Yes ☐ No • Married? ☐Yes ☐ No • Employed? ☐ Yes (complete Section C) ☐ No • Is child's spouse employed? ☐ Yes ☐ No If yes, complete Section C	• through his/her own employer? ☐ Yes ☐ No If yes, complete Section D • through his/her spouse's employer? ☐ Yes ☐ No If yes, complete Section D

C. Employer Name/Address and Phone number: If your child is employed, provide employer name, address and phone number. If the child is married and the spouse is employed, provide information about the spouse's employer.

Adult Child's Employer Name:	
Employer Address and Phone Number:	
Adult Child's Spouse's Name:	
Adult Child's Spouse's Employer Name:	
Employer Address and Phone number:	

D. Eligibility for Other Health Care Coverage: Complete the following section if your adult child is currently ***eligible for*** health coverage either through his/her own employment or his/her spouse's employment, even if not enrolled in coverage.

Policyholder's Name:	Policyholder relationship to Child ☐ Self ☐ Child's spouse	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:

Please sign and notarize the last page of this form.

Participant (Employee/Retiree) Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my child's eligibility for Plan coverage will be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature_____ Date_____

State of _____)

)

County of _____)

On the _____ day of _____, 20_____ before me came _____, to me known and known to me to be the person described in and who executed the foregoing statement and (s)he duly acknowledged to me that (s)he executed the same.

_____Notary Public

Adult Child's Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan Office to contact my employer to verify the existence of other coverage that may be available to me through that employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my eligibility for Plan coverage will be terminated retroactively and I and my parent will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature_____ Date_____

Adult Child's Spouse's Statement (if Adult Child listed above is married): I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan Office to contact my employer to verify the existence of other coverage that may be available to my spouse through my employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my spouse's eligibility for Plan coverage will be terminated retroactively and my spouse and his/her parent will be liable for any claims that were paid erroneously based on the false or misleading information. **I understand I am <u>not</u> eligible for coverage under this plan**.

Signature_____ Date_____

NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

Joseph Epstein
Executive Director

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

UNION TRUSTEES
Frank G. Spencer
Co-Chairman
John Ballantyne
Douglas J. McCarron
Paul Tyznar

MANAGEMENT TRUSTEES
David T. Meberg
Co-Chairman
Catherine Condon
John DeLollis
Paul O'Brien
Kevin O'Callaghan
Bryan Winter

March 2012

SUMMARY OF MATERIAL MODIFICATIONS
NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

TO: Active Employees of Participating Employers and Employer Associations and Their Eligible Dependents

FROM: Board of Trustees

RE: Benefit Changes

As we previously advised, the Trustees have been considering changes to the benefits available through the New York City District Council of Carpenters Welfare Fund ("Welfare Fund") in order to control costs and ensure the Welfare Fund's financial stability for the future. The Trustees recently adopted changes to the Welfare Fund that go into effect on **June 1, 2012**. This document is a Summary of Material Modifications ("SMM") intended to notify you of these changes. Please read this SMM carefully and share it with your family. You should keep it with the Summary Plan Description ("SPD") that was previously provided to you. If you have any questions, please contact the Fund Office at 395 Hudson Street, New York, New York 10014; telephone 800-529-3863 between 8:30 a.m. and 5 p.m., Monday through Friday.

Retirees and surviving spouses are receiving different SMMs since the changes that apply to these groups are different than those described in this SMM. Please keep this in mind if you discuss the changes with other participants.

The changes are listed below. Please review this SMM for important information about each of the changes. As noted, the effective date of each of these changes is June 1, 2012.

- New in-network deductible of $400 per individual and $1,000 per family
- Increase in out-of-network deductible from $200 per individual to $750 per individual and from $500 per family to $1,875 per family

- 10% co-insurance for certain in-network services
- Increase out-of-network co-insurance from 20% to 30%
- Increase emergency room co-payment from $50 to $200
- New in-network out-of-pocket maximum of $1,500 per individual and $3,750 per family
- Increase out-of-network out-of-pocket maximum from $2,000 per individual to $3,000 per individual and from $5,000 per family to $7,500 per family
- Behavioral health benefits and hospital and medical benefits are subject to the same deductibles and co-payments
- Increase retail and mail order prescription co-payments by $5
- Require payment of difference between brand-name name drug and generic drugs purchased through the mail order program
- Require step therapy for drugs used to treat certain stomach conditions
- Elimination of dental benefits
- Elimination of vision benefits
- Loss of "grandfathered plan" status under health care reform legislation
- Extension of dependent coverage to adult children even if they have other employment-based coverage
- Full coverage of certain preventive services without requirement for deductibles, co-payment or co-insurance
- Network changes

HOSPITAL AND MEDICAL

DEDUCTIBLE

In-Network Deductible

You will be responsible for satisfying an in-network deductible of $400 per individual and $1,000 per family. For 2012, the in-network deductible will be pro-rated to reflect that it is being introduced mid-year. The in-network deductible for the period June 1 through December 31, 2012 will be $233.33 per individual and $583.33 per family. If you cover only one dependent, you will each have to satisfy the individual deductible.

The in-network deductible will apply to services that do not have a co-payment such as in-patient room and board, services you receive while an in-patient, home health care, durable medical equipment, dialysis and other out-patient treatment. As explained below, the in -network deductible will not apply to certain diagnostic testing and preventive services.

Out-of-Network Deductible

The out-of-network deductible is increasing from $200 per individual to $750 per individual, and from $500 per family to $1,875 per family. For 2012, the increase in the out-of-network deductible will be pro-rated to reflect that it is being changed mid-year. The in-network deductible for the period June 1 through December 31, 2012 will be $520.83 per individual

and $1,302.08 per family. If you cover only one dependent, you will each have to separately satisfy the individual deductible.

CO-INSURANCE

In-Network Co-Insurance

You will be responsible for a portion of the costs that are subject to the in-network or out-of-network deductible. This amount is known as co-insurance. The Welfare Fund will pay 90% of in-network fees after the deductible has been satisfied. You will be responsible for the remaining 10%.

Out-of-Network Co-Insurance

The Welfare Fund will pay 70% of the Allowed Amount for out-of-network services after the deductible has been satisfied. You will be responsible for the remaining 30% of the Allowed Amount as well as any part of the fee that exceeds the Allowed Amount.

CO-PAYMENTS

Emergency Room Co-Payments

The co-payment for an emergency room visit is increasing from $50 to $200. You will not be required to pay the co-payment if you are admitted within 24 hours of your emergency room visit. Emergency room co-payments will not be included in determining whether you have met your annual deductible.

OUT-OF-POCKET MAXIMUM

In-Network

The Welfare Fund will pay 100% of the network fee or Allowed Amount for the balance of the calendar year if the amount you spend in deductibles and co-insurance reaches certain limits. The annual out-of-pocket maximum for in-network services will be $1,500 per individual, and $3,750 per family. For 2012, the annual out-of-pocket maximum for in-network services will be pro-rated to reflect that it is being introduced mid-year. The out-of-pocket maximum for in-network services for the period from June 1 through December 31, 2012 will be $875.00 per individual and $2,187.50 per family.

Out-of-Network

The out-of-pocket maximum for out-of-network services is increasing from $2,000 per individual to $3,000 per individual, and from $5,000 per family to $7,500 per family. For 2012, the annual out-of-pocket maximum for out-of-network services will be pro-rated to reflect that it is being changed mid-year. The out-of-pocket maximum for out-of-network services for the period from June 1 through December 31, 2012 will be $2,583.33 per individual and $6,458.33 per family.

The new co-payments, deductibles, co-insurance and out-of-pocket maximum amounts for 2012 are summarized in the charts at the end of this memo.

PRESCRIPTION DRUGS

Co-Payments

All co-payments for retail and mail prescriptions are increasing by $5.00 per prescription. The new co-payments are summarized in the chart below:

Type of Drug	Retail (up to a 34-day supply)	Mail Order (up to a 90-day supply)
Generic	$15	$25
Preferred Brand	$25	$45
Non-Preferred Brand	$40	$75

Member Pay the Difference

The current "member-pay-the-difference" program at retail pharmacies that applies to brand-name drugs when a generic is available will also apply to mail-order prescriptions. If you purchase a brand-name drug through the mail order pharmacy service when a generic is available, you will be responsible for the $25 co-payment for mail order generic drugs plus the difference in cost between the brand-name drug and the generic drug.

Step Therapy For Proton Pump Inhibitor Drugs

The way the Welfare Fund covers proton pump inhibitor drugs used to treat certain stomach conditions will change to better control costs and ensure appropriate treatment. A step-therapy program is being implemented to encourage patients to evaluate less expensive treatments. Many patients can be successfully treated with more established medications that have lower costs than the newer drugs. The patient, in consultation with the physician, will move from one step to another if the treatment is not successful. Medco will send information about this program to all individuals who are receiving proton pump inhibitors under separate cover during May 2012. If you do not progress through the steps, you will be required to pay the full cost of the medication instead of a co-payment.

A chart summarizing the prescription drug changes is enclosed.

DENTAL PROGRAM

The Welfare Fund will no longer provide dental benefits on or after June 1, 2012. Dental work that is already in progress will not be covered unless the services are provided before June 1, 2012 or you or a dependent is receiving certain types of dental treatment. Coverage for the services described below will be extended for 90 days so that the work can be completed:

Limited Extension of Dental Benefits	
Service	**Extension of Coverage Applies If:**
• Crowns, fixed bridgework and full or partial dentures	• Impressions were taken and/or teeth were prepared before June 1, 2012
• Orthodontic appliances and active treatment	• Impressions were taken before June 1, 2012
• Root canal therapy	• Pulp chamber was opened before June 1, 2012
• There is no extension of dental benefits for any service other than those noted above.	

Claims for dental services provided before June 1, 2012 should be submitted as soon as possible to the dental network you selected.

VISION BENEFIT

The Welfare Fund will no longer provide vision benefits on or after June 1, 2012. Claims for vision services provided before June 1, 2012 should be submitted as soon as possible to the claims administrator.

LOSS OF GRANDFATHERED PLAN STATUS

We previously advised you of the Welfare Plan's status as a "grandfathered health plan" under the health care reform legislation known as the Patient Protection and Affordable Care Act. As of June 1, 2012, the Welfare Fund will no longer be a "grandfathered health plan" under the law. Certain changes in coverage that are required because of the change in the Welfare Fund's status are described in this SMM. You will be receiving additional information about additional protections available to you due to this change in status.

ADDITIONAL EXTENSION OF WELFARE FUND COVERAGE FOR ADULT CHILDREN

The Welfare Fund currently covers your eligible dependent children until the age of 26 unless he/she is eligible for coverage under another employer-sponsored health plan (other than a group health plan of a parent). Effective June 1, 2012, your eligible dependent children will be eligible for coverage under the Welfare Fund *even if* he/she is eligible for coverage under another employer-sponsored health plan.

If you have a child who is not currently covered under the Welfare Fund because he/she is eligible for health coverage through their employment or through their spouse's employment, the child may be re-enrolled in the Welfare Fund as of June 1, 2012. (Please note that the extension of coverage does not apply to your adult child's spouse or other

dependents.) The enrollment form to add a dependent is available on our website (www.nyccbf.org) or by contacting the Fund Office.

NO COST-SHARING FOR CERTAIN SERVICES

The Welfare Fund will cover the following preventive services received from in-network providers without any cost-sharing (*i.e.*, at no cost to you and with no requirement that you satisfy the annual deductible). The services for which there is no cost-sharing:

1. Annual physical exam
2. Diagnostic screening tests for cholesterol, diabetes, colorectal cancer, routine prostate specific antigen (PSA)
3. Well-Woman office care visits
4. Pap smears, bone density testing, mammogram
5. Well-Child Care services
6. Standard immunizations

If you receive these services from an out-of-network provider, you will be responsible for a portion of the cost. The Welfare Fund will cover these services of a non-network provider in the same way it covers other out-of-network expenses (subject to the deductible and co-insurance). Please refer to the SPD for more information.

NETWORK PROVIDERS

Hospital and Medical

Hospital and medical coverage is currently offered through an "EPO" – an exclusive provider organization. Under the current arrangement, in-network benefits are administered by Empire BlueCross BlueShield ("Empire") and out-of-network benefits are administered by C&R Consulting. The EPO plan is being replaced with the Empire Point of Service ("POS") plan. The POS Plan is similar to the EPO Plan. Under the POS Plan, you will be able to use physicians both in and out of the Empire POS network, subject to additional costs described above and in the SPD for out-of-network services. Empire will process all claims including out-of-network claims. Please note that there is a slight change in the list of physicians participating in the POS network. You may contact your providers to confirm that they participate in Empire's POS network. You may also log onto www.empireblue.com and follow the prompts to locate a provider; select the POS network from the options available in the drop-down menu.

Empire may grant 90-day exceptions in cases where there is a need for continuity of care (*e.g.*, pregnancy in the third trimester, after surgery, during chemotherapy). If you are seeing a provider who does not participate in Empire's POS network, contact Empire at 800-553-9603 to discuss whether your situation qualifies for an exception so your provider will be considered to be in-network for a period of time after May 31, 2012.

Behavioral Health

Behavioral health services will no longer be subject to separate deductibles or co-insurance but will be subject to the same amounts and percentages that apply to in-network and out-of-network medical and hospital providers.

Empire will provide behavioral health services instead of CIGNA. Please contact Empire at 800-553-9603 to coordinate behavioral health services including the Member Assistance Plan benefits and substance abuse treatment.

If you or a family member is currently receiving treatment that has been coordinated through CIGNA, please contact CIGNA at 888-325-3986 to make transition arrangements

NEW IDENTIFICATION CARDS

You will be receiving new identification cards from Empire and Medco by the end of May 2012.

Welfare Fund Co-Payments, Deductibles and Co-Insurance 2012		
	In-Network Empire POS/PPO & Behavioral Health	**Out-Of-Network Any licensed provider**
Co-payments for office visits including chiropractic visits, second/third surgical opinions, diabetes education/management, allergy care, physical/occupational/speech/vision therapy	$20 for primary care providers or $25 for specialists	N/A
Co-payment for Emergency Room visit • Waived if patient is admitted within 24 hours	$200	N/A
Deductible • You are responsible for this amount before the Welfare Fund pays for any covered services. • This deductible applies to behavioral health services. • The deductible does not apply to services that have a co-payment. • Co-payments and amounts in excess of the Allowed Amount do not apply toward the deductible.	**Annual** $400/individual $1,000/family **6/1 – 12/31/2012** $233.33/individual $583.33/family	**Annual** $750/individual $1,875/family **6/1 – 12/31/2012** $520.83/individual $1,302.08/family
Co-Insurance The Welfare Fund will pay the percentage indicated. If you see an out-of-network provider, you are also responsible for any fee that is above the Allowed Amount.	90% of network fee	70% of the Allowed Amount

Welfare Fund Out-of-Pocket Maximum 2012		
	In-Network Empire POS/PPO & Behavioral Health	**Out-Of-Network Any licensed provider**
Out-of-Pocket Maximum Welfare Fund will pay 100% of network fee or the Allowed Amount for the rest of the calendar year once you reach these amounts. Deductibles, co-payments and amounts in excess of the Allowed Amount do not count toward the out-of-pocket maximum.	**Annual** $1,500/individual $3,750/family **6/1 – 12/31/2012** $875/individual $2,187.50/family	**Annual** $3,000/individual $7,500/family **6/1 – 12/31/2012** $2,583.33/individual $6,458.33/family

Welfare Fund Prescription Co-Payments 2012			
	Generic	**Preferred Brand-Name**	**Non-Preferred Brand-Name**
Participating Retail Pharmacy • Up to a 34-day supply • 3 fills at retail permitted; mandatory mail order thereafter	$15	$25	$40
Medco by Mail • Up to a 90-day supply	$25	$45	$75

- **Brand Name when Generic is Available** – you will be responsible for the Generic Co-payment plus the difference in cost between the generic and brand-name drug at retail and mail order.
- **Step-Therapy** program will apply to proton pump inhibitor treatment.
- Quantity and frequency of refills are limited on certain medications.