NEW YORK DISTRICT COUNCIL OF CARPENTERS

BENEFIT FUNDS

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SUMMARY OF MATERIAL MODIFICATIONS TO THE NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND SUMMARY PLAN DESCRIPTION

To: All Welfare Fund Participants

From: Board of Trustees

Date: July 19, 2013

Re: Amendments to the Welfare Fund Summary Plan Description

This Summary of Material Modification ("SMM") is intended to notify you of certain changes to the Summary Plan Description ("SPD") for the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund"). Please read this summary carefully and keep it with the SPD that was previously provided to you.

If you have any questions about any of the following changes, please call the Fund Office.

Lawsuits

Any action by a Participant or Beneficiary for benefits following a denial of an appeal must be filed within 365 days from the notice of the denial of the appeal. Any such action may only be filed in the United States District Court for the Southern District of New York in New York County, New York.

GCC/IBT 353-C

Recovery of Overpayments

If a payment to a participant or dependent or provider is determined to be paid in error or otherwise be an overpayment, the Board of Trustees may commence legal action to recover the overpayment and/or offset future claim payments to recover the amount overpaid.

Claims and Appeals Procedures

The following is a summary of changes to the Welfare Funds' Claims and Appeals Procedures which are effective for appeals reviewed on or after June 1, 2012. These changes are required by the heath care law, the Patient Protection and Affordable Care Act.

1. Right to Appeal Rescissions of Coverage

A "rescission of coverage" refers to a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent that the rescission is due to a failure to pay timely premiums towards coverage or fraud. You may appeal a rescission of coverage even if the rescission does not have an adverse effect on any particular benefit. To appeal a rescission of coverage follow the Claims and Appeals Procedures set forth in the SPD. In addition, rescissions of coverage are eligible for External Review as described below.

2. External Review of Certain Types of Claims

Claims that involve (1) medical judgment or (2) a rescission of coverage are eligible for external review. Some examples of situations in which a claim is considered to involve medical judgment include adverse benefit determinations (full or partial claim denials) based on the Welfare Fund's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or based on the Welfare Fund's determination that a treatment is experimental or investigational. As part of the External Review process, Empire BlueCross and BlueShield ("Empire") has contracted with at least three (3) Independent Review Organizations ("IROs") and has taken other steps to ensure that the External Review Process is independent and without bias.

For medical and hospital administered by Empire benefits, please follow the following process for External Review:

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review.

You must submit your request for External Review to Empire within four (4) months of the notice of your final internal adverse determination. A request for an External Review must be in writing unless Empire determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for the internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Empire's decision, can be sent between Empire and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Empire at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless Empire determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem National Accounts
ATTN: Appeals, P.O. Box 5073
Middletown, NY 10940 – 9073

You are not required to request an External Review in order to fulfill your appeal procedure obligations. Your decision to seek External Review will not affect your rights to any other benefits under the Welfare Fund. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through the Employee Retirement Income Security Act of 1974, as amended.