New York City District Council of Carpenters Welfare Fund

SUMMARY PLAN DESCRIPTION

For Employees and Retirees of the City of New York

EFFECTIVE FEBRUARY 1, 2019

New York City District Council of Carpenters
BENEFIT FUNDS

New York City
District Council of Carpenters Welfare Fund

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ABOUT THIS BOOK

This book summarizes the benefits provided by the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund," the "Fund," or the "Plan") for employees and retirees of the City of New York as of February 1, 2019. It is both the Plan document and the Summary Plan Description (the "SPD"). It supersedes all prior SPDs and all Summaries of Material Modifications ("SMMs") issued prior to this SPD.

This SPD is intended to provide an easy-to-understand explanation of the benefits available through the Fund and to offer a comprehensive resource you can use when you or your family members need information about your benefits. It has been organized to give you quick access to easy-to-understand explanations of your benefits.

To best utilize your benefits, please review this SPD carefully and share it with your family. We hope this information will answer all of your questions.

From time to time, there may be changes in the Fund's benefits and/or procedures. When that happens, you will be notified in writing of any change through an SMM. You should keep these SMMs with this SPD. SMMs will be sent to you at the address that appears in Fund Office records. For this reason, be sure to notify the Fund Office if your address changes.

This SPD uses everyday language to explain your benefits; however, there are certain technical terms that apply to the Fund. We have defined these terms in the **Glossary** section at the end of the SPD and the first time they appear, they are in bold type. Words that are capitalized – such as "Active Employee," "Retiree" and "Covered Employment" – are generally defined in the **Glossary**. In some cases, they are also defined in the text.

This SPD summarizes only the benefits you receive under the Welfare Fund. It does not describe your other employment-related benefits.

Ayuda en Español Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el New York City District Council of Carpenters Welfare Fund. Si usted tiene dificultad en entender cualquier parte de este folleto, puede communicarse con la oficinia del plan en 395 Hudson Street, New York, NY 10014. Las horas de oficina son de 8:00 a.m. a 5:30 p.m., lunes a jueves, y 8:00 a.m. a 5:00 p.m. en viernes. También puede llamar la oficina del plan al 800-529-3863 para ayuda.

OVERVIEW OF WELFARE FUND BENEFITS

The New York City District Council of Carpenters Welfare Fund provides the following supplemental benefits:

- A reimbursement program to help offset some of your health care costs;
- Dental, vision, and hearing benefits;
- Short-term disability benefits;
- Life insurance benefits; and
- A scholarship program

For More Information

ABOUT YOUR . . .	CONTACT . . .
Reimbursement Program	**Administrative Services Only ("ASO")** 800-537-1238
Vision Coverage and Hearing Exams & Hearing Aids Coverage	**Comprehensive Professional Systems, Inc.** 212-675-5745 **www.cpshearing.com** or **www.cpsoptical.com** **General Vision Services** 212-594-2580 **www.generalvision.com/hearing**
Dental Coverage	**Administrative Services Only Inc./** **Self-Insured Dental Services ("ASO/SIDS")** 800-537-1238 **www.asonet.com**
Life Insurance Coverage	**Amalgamated Life Insurance Company** 914-367-5000
Short-Term Disability Coverage	**Fund Office** 800-529-3863 or 212-366-7373 **www.nyccbf.org**
Scholarship and Recognition Program	**International Scholarship and Tuition Services ("ISTS")** 855-670-4787 **https://aim.applyists.net/NYCDCC**

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Discrimination is Against the Law

The Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Welfare Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Fund's Civil Rights Coordinator, Gerard Minetello.

If you believe that the Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance via mail with: Civil Rights Coordinator, Gerard Minetello, at 395 Hudson Street, 9th Floor, New York, New York, 10014. You can also file a grievance in person, via fax at (212) 366-7444, Attn.- Gerard Minetello, or via email at **GMinetello@nyccbf.org**.

If you need help filing a grievance, Mr. Minetello is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201. You can also file a grievance via phone at (800) 368-1019, (800) 537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-529-3863.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-529-3863.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-529-3863.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-529-3863.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-800-529-3863 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-529-3863.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-529-3863.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-529-3863.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-529-3863.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-529-3863.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-529-3863.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-529-3863.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-529-3863.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-529-3863.

(رقم. هاتف الصم والبكم:

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-529-3863.

ABOUT YOUR PARTICIPATION

This section describes the eligibility rules for reimbursement, dental, life insurance, vision, and hearing coverage that apply to eligible **Active** and **Retired Employees** and their covered dependents. The rules for short-term disability and scholarship benefits are explained in the sections on those benefits.

Eligibility for Benefit Programs

BENEFIT	WHO IS ELIGIBLE
Reimbursement Program	Actives and Retirees
Vision Benefits and Hearing Exams & Hearing Aids Benefits	Actives and Retirees
Dental Benefits	Actives and Retirees
Life Insurance Benefits	Actives and Retirees
Short-Term Disability Benefits	Actives
Scholarship and Recognition Program	Actives and Retirees

Individuals residing abroad. The Plan **does not** provide dental, hearing, or vision coverage for individuals residing outside the United States.

Eligibility for Active Employees

You are eligible for coverage on the first day of the month in which the City of New York (the "City") makes contributions to the Fund on your behalf pursuant to a collective bargaining agreement between the City and the New York City and Vicinity District Council of the United Brotherhood of Carpenters and Joiners of America (the "District Council" or the "Union").

The term **"Covered Employment"** means employment for which the City contributes to the Fund on your behalf.

Eligibility for Retirees

When you retire, your coverage will continue as a **Retiree** only if the City makes Retiree contributions to the Fund on your behalf.

Eligibility for Dependents

If you are covered, your eligible dependents may be covered for dental, vision, and hearing benefits. They may also be covered under the Reimbursement Program if they are enrolled in a health plan that satisfies the "minimum value" requirement under the Patient Protection and Affordable Care Act of 2010 ("ACA"). Eligible dependents include your:

- **Spouse** to whom you are legally married or a registered **Domestic Partner** of the same or opposite sex.
- **Children**, until the end of the month in which they reach age 26.
- **Dependent Parents** who live in the United States and whom you claim as dependents on your federal income tax return if you are not married and have no eligible Children.

Under the Fund, Children include:

- Your biological Children;
- Your stepchildren;
- Your legally adopted Children or Children placed for adoption, 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, and for whom foster care payments are being made and a petition for adoption has been filed;
- Children for whom you are the court-appointed legal custodian or guardian and for whom you are required to provide support. All court orders must meet certain requirements that vary from state to state; and/or
- Your unmarried Children, regardless of age who are incapable of self-sustaining employment because of disability, who meet each of the following requirements: (a) he/she became disabled prior to reaching the age at which the dependent coverage would otherwise terminate, (b) he/she was covered under the Fund prior to reaching the age at which the dependent coverage would otherwise terminate, (c) he/she is dependent on you for more than half of his/her financial support and maintenance, and (d) if he/she is 26 or older, he/she **must** have a Social Security Disability Award.

Coverage for your eligible dependents starts at the same time your coverage starts, subject to your submission of all required enrollment documents. You must provide, as applicable:

RELATIONSHIP	DESCRIPTION	DOCUMENTATION*
Spouse	• Your current lawful spouse • An ex-spouse is not an eligible dependent	• Copy of certified marriage certificate; **AND** • Copy of your spouse's Social Security Card; **AND** • Birth certificate (if spouse's date of birth is not stated on marriage certificate).

RELATIONSHIP	DESCRIPTION	DOCUMENTATION*
Domestic Partner	• Two people, both of whom are 18 years of age or older; neither of whom is married or related by blood in a manner that would bar their marriage in New York State; who have a committed personal relationship; who live together and have been living together on a continuous basis; who have registered as domestic partners; and who have not terminated the domestic partnership.	• Domestic Partnership Registration Certificate issued by the Office of the City of New York Clerk or a similar certificate issued through another municipality or government; and • Domestic partner's birth certificate; **AND** • Domestic partner's Social Security card; **AND** • Proof of financial interdependence such as a mortgage statement, lease agreement, utility bill, bank statement, credit card statement, or property tax statement. Such agreement/statement must include the names of both domestic partners.
Child up to Age 26 (end of month of 26th birthday)	• Biological Child	• Copy of certified birth certificate; **AND** • Copy of your dependent's Social Security Card.
	• Adopted Child ○ a Child placed in your home by a licensed placement agency in connection with adoption; **OR** ○ a foster Child for whom foster care payments are made and a petition for adoption has been filed.	• Copy of your dependent's Social Security Card; **AND** • Birth certificate showing adoptive parents; **OR** • Certificate of adoption; **OR** • Adoption Agency acknowledgment of intent to adopt.

RELATIONSHIP	DESCRIPTION	DOCUMENTATION*
	• Stepchild; Child of a Domestic Partner	• Copy of certified marriage certificate or proof of Domestic Partnership between you and the parent of the Child; **AND** • Birth certificate of the stepchild or child of Domestic Partner; **AND** • Copy of your dependent's Social Security Card; **AND** • Any court order or agreement that specifies obligation of medical coverage.
	• Qualified Medical Child Support Order ("QMCSO") • Any Child for whom you are required to cover due to a court order (provided the child meets the definition of a child under the Plan)	• Copy of your dependent's Social Security Card; **AND** • Court order signed by a judge; **OR** • Medical support order issued by a state agency.
Child for Whom You are the Court-Appointed Legal Custodian or Guardian	• Any Child for whom you are the court-appointed legal custodian or guardian and for whom you are required to provide support	• Copy of certified birth certificate; **AND** • Copy of your dependent's Social Security Card; **AND** • Court order signed by a judge.

RELATIONSHIP	DESCRIPTION	DOCUMENTATION*
Disabled Child*	• A Child of any age who satisfies **all** the following conditions: • The Child depends on you for more than one-half of his/her financial support; • The Child lives 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 the Child resides in a treatment center; • The Child was incapacitated before reaching the limiting age and while covered under the Fund; • If your Child is over age 26, he/she must have a Social Security Disability Award; **AND** • You provide the required proof of 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.	• Copy of your dependent's Social Security Card; **AND** • Birth Certificate; **AND** • Marriage certificate between you and Child's parent if stepchild; **AND** • Social Security Disability award; **AND** • Application for Over-Age Dependent Coverage.

RELATIONSHIP	DESCRIPTION	DOCUMENTATION*
Dependent Parents	• A dependent parent who is eligible for tax-free health coverage as a "qualifying relative" pursuant to Internal Revenue Code Section 152(d) who is lawfully claimed as a dependent on the employee's federal income tax return for each plan year for which coverage is provided.	• Copy of your (the employee's) birth certificate or adoption papers (if not already on file); **AND** • Copy of tax return for each Plan Year for which coverage is provided; **AND** • Copy of parent's Social Security card; **AND** • Copy of parent's birth certificate.

If you acquire dependents after your coverage begins, their coverage will commence on the date they become eligible dependents if you timely notify the Fund Office as described in the section of this SPD entitled **Changes in Status.**

The Fund Office may investigate the status of any Dependent at any time. The Fund Office may require at any time copies of court orders, property settlement agreements, divorce orders, birth certificates, paternity determinations, guardianship orders, adoption papers, tax returns, Social Security award/denial letters, or any other document or information related to the determination of an individual's status as a Dependent. A failure to provide the requested documentation may result in the termination of coverage for you and your dependents.

*** Note for Participants Who Are Submitting Non-United States Documents as Proof of Eligibility**

If your dependent documentation (such as a marriage certificate or a birth certificate) was issued in a country other than the United States and is not in English, you will need to provide a copy of the document translated into English for it to be acceptable proof of dependent status. Any such document **must** be completely translated into English and **must** be certified with a letter of accuracy from the translator.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order ("QMCSO") is an order issued by a state court or agency that requires an individual to provide coverage under a group health plan to a Child. Upon receipt, the Fund will review the order in accordance with the Fund's QMCSO Procedures. For more information on QMCSOs, please contact the Fund Office.

Changes in Status

You must notify the Fund Office immediately by calling toll-free (800) 529-3863 if you have either a change of address or you experience one of the following changes in status:

- Marriage, divorce, or annulment;
- Commencement or termination of a registered domestic partner relationship;
- Birth, adoption, or placement of a Child for adoption;

- Commencement of Court-appointed guardianship;
- A dependent Child ceases to be eligible for dependent coverage;
- You take a leave of absence for military service;
- You take a leave of absence for family or medical purposes; or
- A covered person dies.

What Happens if You Get Divorced or Terminate Your Domestic Partnership?

If you get divorced or your domestic partnership is terminated, you **must** notify the Fund Office **within 60 days** of that life event and submit a copy of your divorce judgment or the termination of your domestic partnership. **You and your former spouse/domestic partner will be jointly and severally liable for any amounts paid on behalf of your former spouse/domestic partner and/or stepchild following a divorce/domestic partnership termination plus interest and collection costs.** Your eligibility and the eligibility of your Eligible Dependent(s) will be permanently terminated if you fail to timely notify the Fund Office of your divorce/domestic partner termination and if you do not immediately reimburse the Fund for any claims paid in error as a result of your failure to notify the Fund of your life event.

IMPORTANT: A divorce or domestic partner termination **does not** change your **Beneficiary** or invalidate your prior designation of your former spouse/domestic partner as Beneficiary for your life insurance benefit. If you are divorced or terminated a domestic partnership and wish to change your Beneficiary for the life insurance benefit, you must submit a new Beneficiary designation form to the Fund Office.

Enrollment

Initial enrollment. You will receive your initial enrollment package from the Fund Office when you become eligible for benefits. This package will include an enrollment form for you to complete and return along with birth certificate(s) and other supporting materials within 30 days after you first become eligible. In order for your Dependents to be covered, you will need to enroll them when you are first eligible for coverage. If you do not enroll your Dependents within 30 days after you become eligible, you may enroll them at a later date, but coverage will not be effective until the first of the month following the month the Fund Office receives the completed enrollment package and necessary supporting documentation.

The Fund's enrollment form is in addition to any that you must complete for the City to enroll in its basic (medical/hospital) benefits.

Special enrollment. If you decline enrollment for (or do not enroll) yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). You must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

If you have a new Dependent as a result of marriage, Domestic Partnership, birth, adoption, or placement for adoption, you may enroll yourself and your Dependents if you request enrollment within 30 days after the event.

You and your Dependents may also enroll in this Plan if you or your Dependents have coverage through Medicaid or a State Children's Health Insurance Program ("CHIP") and you or your Dependents lose eligibility for that coverage. You must request enrollment within 60 days after you or your Dependents' Medicaid or CHIP coverage ends.

You and your Dependents may also enroll in this Plan if you or your Dependents become eligible for a premium assistance program through Medicaid or CHIP. You must request enrollment within 60 days after you or your Dependents are determined to be eligible for such assistance.

If you enroll within the deadlines described above, coverage will be effective as of the date of the event. If you do not enroll your Dependents within the deadlines shown above, you may enroll them at a later date, but coverage will not be effective until the first of the month following the month in which the Fund Office receives the completed enrollment package with the necessary supporting documentation. To request special enrollment or obtain more information, contact the Fund Office.

Fraud or Otherwise Improper Use of Coverage

The authority to determine whether you have engaged in fraud or whether an ineligible dependent used coverage to which he/she was not eligible rests with the Board of Trustees. If the Board of Trustees determines that you have committed fraud or that an ineligible dependent used coverage to which he/she was not entitled, you and all of your dependents will be permanently ineligible for Active and/or Retiree Welfare coverage.

Any participant who is determined, in the sole discretion of the Board of Trustees, to have defrauded the Welfare Fund or assisted another individual or entity to defraud the Welfare Fund in any form or manner or any participant whose ineligible dependent used coverage to which he/she was not entitled will be permanently ineligible for Active and/or Retiree Welfare coverage. The participant's dependents will also be permanently ineligible for Active and/or Retiree Welfare coverage.

For example, if you are determined, in the sole discretion of the Board of Trustees, to have worked "off the books," you and your dependents will be permanently ineligible for Active and/or Retiree Welfare coverage. Working "off the books" is a situation in which an employer and an employee conspire or otherwise agree or arrange that the actual number of hours worked by the employee will not be reported to the Welfare Fund.

Another example which will result in the loss of coverage is if you and/or your former spouse fail to notify the Fund of your divorce, or if you misrepresent your marital status and your spouse continues to use coverage under the Fund. In that event, you and your dependents will be permanently ineligible for coverage unless you or the ineligible dependent promptly reimburse the Fund the full amount of claims paid on behalf of the ineligible individual plus interest and collection costs.

The termination of Welfare Fund coverage due to fraud or the improper use of coverage by an individual (such as a former spouse or other ineligible dependent) will be effective as soon as

administratively practical following the Trustees' determination of fraud or improper use of coverage and the issuance of written notice of the Trustees' determination to you and your dependents. Depending on the circumstances, you may be required to reimburse the Fund for any benefits it paid on behalf of you or your dependents during the period at issue.

If you and your dependents become ineligible for Welfare Fund coverage due to a determination that you committed fraud or due to an ineligible dependent improperly using coverage under the Fund, neither you nor your dependents will be entitled to elect COBRA Continuation Coverage since loss of coverage in these circumstances is not a qualifying event under COBRA.

Coverage During Certain Leaves of Absence

Family and Medical Leave Act

Under the Family and Medical Leave Act of 1993 ("FMLA"), you may be able to take up to 12 weeks of unpaid leave during any 12-month period:

- To care for a newly born or adopted Child;
- To care for a spouse, parent or Child who has a serious health problem;
- If you have a serious health problem that prevents you from performing your job; or
- If you have a qualifying need because your spouse, your Child or your parent is called to active duty.

In addition, pursuant to the amendments made to the FMLA by the National Defense Authorization Act of 2008, you may take up to 26 weeks of unpaid leave during any 12-month period to care for a service member who is your spouse, Child, parent or next of kin who is undergoing treatment, recuperation or therapy for an Illness or Injury that occurred in the line of duty, and is in outpatient status or on the armed services' temporary retired list.

During your FMLA leave, you will maintain the coverage for which you were eligible at the time of your leave until the end of your leave, as long as your employer properly grants the leave under the FMLA and makes the required notifications and contributions to the Fund on your behalf.

The Fund has no role in granting FMLA leave. Your employer can grant FMLA leave, and your Fund coverage will continue for as long as your employer continues making the required contributions to maintain your eligibility. If your employer stops making contributions on your behalf, or if you exhaust your FMLA leave, COBRA Continuation Coverage may become available. (See page 16 for more information about COBRA.)

If you do not return to work after your FMLA leave ends, you may be required to repay your employer the amount that it contributed to the Fund during your FMLA leave. However, if your failure to return to work is due to the serious health condition of you or a family member or other circumstances beyond your control, the repayment requirement may not apply.

Contact your employer for more information regarding your rights under FMLA.

Military Leave

If you leave employment to enter the uniformed services as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you and your dependents' eligibility for coverage will end. However, if you satisfy the eligibility criteria under USERRA, you may be able to elect to continue health coverage under the Fund.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, coverage under the Fund will continue. If your service continues for 31 days or more, you may elect to continue coverage under the Fund by making monthly self-payments which will be the same amount as COBRA self-payments. (See page 16 for more information about COBRA.) In addition, your dependents may be eligible for health care under the Civilian Health & Medical Program of the Uniformed Services ("TRICARE"). If you and/or your dependents are covered by both this Fund and TRICARE, this Fund pays first, and TRICARE pays second. This Fund will coordinate coverage with TRICARE. See the **Coordination of Benefits** section on page 38 for more information.

If you are eligible and elect to continue coverage under USERRA, your coverage under the Fund may continue (at a maximum) until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after coverage otherwise would end under the Fund.

However, your coverage under USERRA may end before the end of the maximum period (described above). Your coverage will end at midnight on the earliest of the day:

- The Fund ceases to provide any health plan to any employee;
- Your self-payment contribution is due and not paid on a timely basis;
- Your uniformed service ends due to dishonorable discharge or other undesirable conduct; or
- You again become covered under the Fund.

Notice Requirements

You must notify the Fund Office in writing in advance of entering the uniformed services. If you fail to provide advance notice of your uniformed service, you may not be eligible to continue coverage unless the failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may elect to continue coverage and pay all amounts required to continue coverage in accordance with the COBRA election and payment procedures as described starting on page 16. Your continuation coverage will only apply to periods for which the required contribution is paid.

Election, payment and termination of USERRA continuation coverage will be governed by the election, payment and termination rules for COBRA, provided COBRA rules do not conflict with USERRA. COBRA and USERRA run concurrently. This means if you are simultaneously eligible for COBRA and USERRA, you will be provided with the more generous benefit under each law for

periods in which you are eligible for both forms of continuation coverage. If you fail to follow the COBRA rules when electing and paying for USERRA coverage, you may lose the right to continue USERRA coverage. However, if circumstances make it otherwise impossible or unreasonable for you to timely elect and pay for USERRA coverage, the Trustees may, in their sole discretion, reinstate your right to USERRA continuation coverage, provided you pay all amounts required for such continuation coverage.

For more information about continuing your coverage under USERRA, contact the Fund Office.

If You Do Not Continue Coverage Under USERRA

If you do not elect to continue coverage under USERRA, your coverage will end at the end of the month in which you enter the armed forces. If you have dependent coverage at the time you enter the armed services, your eligible dependents may continue coverage under the Fund by electing and making self-payments for COBRA Continuation Coverage**.**

Reinstating Your Coverage

Upon your honorable discharge from uniformed service, you may apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered by your former employer. Reemployment and reinstatement deadlines are based on your length of military service, as follows:

- Less than 31 days—you have one day after discharge (allowing 8 hours for travel) to return to work for a contributing employer;
- More than 30 days but less than 181 days—you have up to 14 days after discharge to return to work for a contributing employer; or
- More than 180 days—you have up to 90 days after discharge to return to work for a contributing employer.

When you are discharged, if you are hospitalized or recovering from an Illness or Injury that was incurred during your uniformed service, you have until the end of the period that is necessary for you to recover to return to work for a contributing employer.

When Coverage Ends

Your eligibility may end for any of the following reasons:

- You or your covered dependents no longer meet the Fund's eligibility requirements;
- The Fund ceases to provide coverage or an insurance company terminates the contract that provides your benefits;
- You or your covered dependents make a false statement on an enrollment form or claim form or otherwise engage in fraud as detailed on page 12 in the **Fraud** section; or,
- Your dependents' coverage will end on the earlier of the date your coverage ends or the last day of the month in which they no longer qualify as eligible dependents under the Fund.

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

- Fraud or intentional misrepresentation (in such cases, you will be provided with 30 days' notice); or
- Non-payment of premiums (including COBRA premiums).

A "rescission of coverage" is a retroactive cancellation or discontinuance of coverage, except to the extent that the rescission is due to a failure to pay timely premiums for 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 starting on page 48.

Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you and any covered dependents may be eligible to continue your coverage under certain circumstances when your coverage would otherwise end. You must make self-payments in order for coverage to continue. The Continuation Coverage includes vision, dental, hearing, and Reimbursement Program benefits that are identical to the coverage you had under the Fund. Continuation coverage is not available for life insurance, disability, or scholarship benefits. In addition, because prior to your COBRA Qualifying Event, you received benefits from two plans, the City for medical/hospital benefits and this Plan for hearing, dental, vision, and Reimbursement Program benefits, when you lose your coverage, you will receive two COBRA applications, one for the City Medical/Hospital Plan and one for this Plan. However, the COBRA elections are independent of each other. You are not required to elect COBRA under the City plan in order to elect COBRA under this Plan nor are you required to elect COBRA under this Plan in order to elect COBRA under the City plan. If you wish to continue your coverage under this Plan (for hearing, dental, vision, and Reimbursement Program benefits), you must complete and timely submit the COBRA Election to the Fund Office within the applicable deadlines. The Fund Office administers COBRA Continuation Coverage.

COBRA Qualifying Events

The following chart shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue. The Fund has the authority to determine whether a qualifying event has occurred with respect to termination of employment and/or reduction in hours of employment.

IF YOU LOSE COVERAGE BECAUSE:	THESE PEOPLE WOULD BE ELIGIBLE	FOR COBRA COVERAGE UP TO
Your employment terminates*	You and your covered Dependents	18 months **
You become ineligible due to reduced work hours	You and your covered Dependents	18 months**
You die	Your covered Dependents	36 months

You divorce***	Your covered former Spouse and stepchildren	36 months
Your Child no longer qualifies for coverage	Your covered Child	36 months

* For any reason other than gross misconduct

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

*** Does not apply to termination of domestic partnerships.

Newly Acquired Dependents

If you acquire a new dependent while your COBRA Continuation Coverage is in effect, you may add that dependent to your coverage by notifying the Fund Office of the change within 30 days of that qualifying event. Adding dependents may increase your premium.

Multiple Qualifying Events While Covered Under COBRA

The maximum period of coverage under COBRA is 36 months, even if you experience another qualifying event while you are already covered under COBRA. If you are covered under COBRA for 18 months because of your termination of employment or reduction in hours, your dependents who were covered at the time of the first qualifying event (spouse, Child or other eligible dependent) may extend coverage for another 18 months if:

- You die;
- You get divorced;
- Your Child is no longer eligible as your dependent under the Fund's rules; or
- You become eligible for Medicare.

For example, let's say you stop working, lose coverage, and you and your covered dependents enroll in COBRA Continuation Coverage for 18 months. Three months after your COBRA Continuation Coverage begins, however, your Child turns age 26 and no longer qualifies for coverage under the Fund. Your Child then can continue COBRA Continuation Coverage separately for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage. Notice to the Fund Office within 60 days of this second event and timely election to continue coverage and self-payment are required to extend coverage.

You, as the eligible employee, are not entitled to COBRA Continuation Coverage for more than 18 months if your employment terminates or you have a reduction in hours (unless you become disabled during the first 60 days of COBRA Continuation Coverage). If you first experience a reduction in hours and then have a termination of employment, the termination of employment is not treated as a second qualifying event and you may not extend your coverage.

Notifying the Fund Office

Both you and the Fund Office have responsibilities when qualifying events occur that make you or your covered dependents eligible for COBRA Continuation Coverage. You have the responsibility to notify the Fund Office when your employment with the City ends. Your family should notify the Fund Office upon your death. You or your dependent must notify the Fund Office in writing within 60 days of a divorce or a Child's loss of dependent status under the Fund. If you do not notify the Fund Office within 60 days of such an event, you and/or your covered dependents will lose the right to elect COBRA Continuation Coverage.

When the Fund Office is timely notified of a qualifying event, you and your covered dependents will be notified of your right to elect COBRA Continuation Coverage, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. For information about the Marketplace, visit **www.healthcare.gov.**

Once you receive a COBRA notice, you have 60 days from the later of (a) the date that coverage would be lost or (b) the date that the notice is provided in which to elect COBRA Continuation Coverage. Your covered dependents have the option of electing coverage independently from you if you choose not to elect COBRA Continuation Coverage. For example, your spouse may elect COBRA Continuation Coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or all Children who are qualified Beneficiaries. A parent may elect to continue coverage on behalf of any Children. You or your spouse can elect COBRA Continuation Coverage on behalf of all qualified Beneficiaries.

In determining whether to elect COBRA Continuation Coverage, you should consider the consequences if you fail to continue your group health coverage. You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment rights at the end of COBRA Continuation Coverage if you elect and maintain COBRA Continuation Coverage for the maximum time available to you.

If you or a dependent provides notice to the Fund Office of:

- A divorce;
- Ineligibility of a dependent for coverage under the Fund; or
- A second qualifying event;

and if you or the dependent are not entitled to COBRA, the Fund Office will notify you in writing of the reason you are not eligible for such coverage.

Health Coverage Alternatives to COBRA

You may also have other options besides COBRA when you lose group health coverage that can be purchased through the Health Insurance Marketplace. In addition, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage. Being eligible for COBRA does not limit your eligibility for a tax-credit. If you do not elect COBRA or if you elect COBRA and your COBRA benefits expire, you and your family may be eligible to enroll in the Marketplace. Coverage could actually cost less than COBRA coverage. To find out more about the Marketplace, its

enrollment periods, and qualifying events, please call (800) 318-2596 or visit **www.healthcare.gov**. You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's Plan) if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Paying for COBRA Continuation Coverage

If you or a covered dependent chooses to continue coverage under COBRA, you or your covered dependent must pay the full cost of the coverage plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, your cost will increase to 150% of the full cost of continued covered during the 19th through the 29th months of coverage.

Your first payment must be made within 45 days after you elect to continue coverage and must include payments for any months retroactive to the day that you and/or your covered dependents' coverage under the Fund ended.

Subsequent payments are due the first of the month and must be made no later than 30 days from that date. A payment is considered made on the date on which it is sent to the Fund. If there is a question as to the date sent, the Fund Office will use the postmark date to determine the date sent.

The aforementioned 30-day period is your grace period. If you pay after the due date but before your grace period expires, the Fund Office will initially terminate your coverage for non-payment of premium effective as of the due date and then reinstate your coverage retroactive to that date when your premium is received. If a payment is received after the grace period expires, your late payment will be returned to you and your coverage will remain terminated as of the last day of the month for which timely payment was made.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage for you and/or your covered dependents may end for any of the following reasons:

- Coverage has continued for the maximum 18-, 29- or 36-month period;
- The Fund no longer provides group health coverage;
- The Fund terminates coverage for cause, such as fraudulent claim submission, on the same basis that coverage could terminate in a similar situation for Active Employees;
- You or a dependent do not pay the cost of your COBRA Coverage when it is due or within any grace period;
- The person electing coverage is widowed or divorced, subsequently remarries and is eligible for coverage under the new spouse's group health plan;
- You are continuing coverage during the 19th to 29th months of a disability and the Social Security Administration determines you are no longer disabled; or
- You or a covered dependent becomes entitled to Medicare after COBRA Continuation Coverage begins.

COBRA Claims

Claims will not be paid unless you have timely elected COBRA Continuation Coverage and paid the premiums.

REIMBURSEMENT PROGRAM

The Fund's Reimbursement Program, which is administered by Administrative Services Only ("ASO"), reimburses Eligible Expenses on a non-taxable basis, subject to an annual maximum. It is intended to qualify as a medical reimbursement plan (health reimbursement arrangement ("HRA")) under §105 and §106 of the Internal Revenue Code of 1986, as amended ("Code"), and regulations issued thereunder, and as an HRA as defined under IRS Notice 2002-45. The Eligible Expenses reimbursed under the Reimbursement Program are intended to be eligible for exclusion from your gross income under Code §105(b).

Eligibility

To be eligible for the Reimbursement Program, you must meet the eligibility rules and be enrolled both in this Plan **and** one of the basic New York City health plans or another group health plan sponsored by another employer, or a group health plan sponsored by your spouse's employer, that meets the "Minimum Value" standard of the ACA. If your group health plan does not meet the Minimum Value standard or you do not provide the necessary proof of enrollment, you will not be eligible for the Reimbursement Program benefit. Since your group health plan's Summary of Benefits and Coverage ("SBC") states whether coverage provided by your group health plan meets the Minimum Value standard, a copy of your SBC must be submitted to ASO when filing a claim. You must also provide ASO with a copy of the health insurance identification ("ID") card listing you and any covered individuals by name and the effective date of coverage.

If you are enrolled in a health plan from the Marketplace Exchanges or other individual health insurance coverage, you are not eligible for this Reimbursement Program benefit and must permanently opt-out as described in the **"Enrolling for Coverage"** section.

Annual Reimbursement Maximums

There is an annual maximum on reimbursement amounts which is determined based on the amount of contributions made by the City on your behalf and the costs of the other benefits offered by the Fund. Your claims will be tracked during each Calendar Year for any reimbursement of Medical Care Expenses incurred during that year. The amount available for reimbursement will be the annual maximum minus the amount of claims for which you have been reimbursed for during a particular year.

Nothing herein will be construed to require the Fund to maintain any trust fund or to segregate any amount for the benefit of any participant, and no participant or other person will have any claim against, right to, security or other interest in any fund, account or asset of the Fund from which any payment under the Reimbursement Program may be made.

Source and Amount of Contributions

Your Reimbursement Program is funded with employer contributions only. You may not contribute to the Reimbursement Program. Under no circumstances will the benefits of the Reimbursement

Program be funded with salary reduction contributions, employer flex credit contributions or otherwise under a cafeteria plan.

In 2019, the annual maximums available for reimbursement are $1,736 per family for Active City Carpenters and $1,694 per family for Retired City Carpenters. These amounts are subject to change on an annual basis.

Use-it or Lose-it

Your Reimbursement Program has a "use-it or lose- it" rule. This means that any monies remaining in your HRA are forfeited if you do not incur an amount in Eligible Medical Care Expenses in a calendar year equal to the maximum amount available for reimbursement and timely submit claims for reimbursement to ASO postmarked by March 31 of the following year. Any unused amounts (or amounts for which claims are not timely submitted) are **not** available for reimbursement in future years. Rather those amounts are permanently forfeited, and the amounts are applied to reduce the administrative expenses of the Reimbursement Program.

Deadline for Filing Reimbursement Claims

All claims for the year ending December 31 must be postmarked by no later than March 31 of the following year in order to be eligible for reimbursement. **If you do not submit claims by the March 31 deadline, you will not be eligible for reimbursement of those claims and any remaining amounts for reimbursement are permanently forfeited.**

Eligible Medical Care Expenses for Reimbursement

Your account can be used for reimbursement of "Medical Care Expenses," which are expenses incurred by you or your dependents for medical care, as defined in Code §§ 105 and 213(d) (including, for example, amounts for certain bills for hospital care, doctors, or dental care that are not covered under your basic health plan coverage). Some examples of eligible expenses include, but are not limited to:

- Deductibles (the amount of hospital, medical, or dental expenses you pay before insurance benefits begin)
- Coinsurance (the amount of hospital, medical, or dental expenses left for you to pay when your bills are partially reimbursed by insurance)
- Co-pays
- Premiums paid for the City Drug Rider or other group coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars)
- Prescription Drug Costs (for prescription drug reimbursement, you must submit proof that you are enrolled in a health plan that satisfies the ACA's minimum value requirement)

To qualify for reimbursement, an expense must:

- be incurred and claimed while you are eligible for reimbursement in accordance with all provisions of the Plan; and
- be substantiated by filing a written claim with ASO and providing evidence that an Eligible Medical Care Expense was incurred; and
- not be reimbursable from any other health plan or insurance; and
- be incurred by you and/or your Dependents for "medical care," as defined in Code Sections 105 and 213(d).

Not all Medical Care Expenses will be considered "Eligible Medical Care Expenses" that qualify for reimbursement. Generally, only Medical Care Expenses within the meaning of Code Section 213 are eligible. See the "**Exclusions**" subsection within this section for a list of expenses that are never payable by this Plan.

How to File a Reimbursement Claim

Only a written request to ASO for reimbursement of an Eligible Medical Care Expense is a claim. You must submit to ASO a claim form and all copies of the itemized bills for the expenses incurred and/or the corresponding Explanations of Benefits ("EOBs") **FROM ALL HEALTH PLANS** covering the patient(s) (along with other documents as described below). You can get a claim form from the Fund Office through its website at **www.nyccbf.org**, or from ASO.

All claims for the year ending December 31 must be postmarked by no later than March 31 of the following year. Otherwise any such amounts that would otherwise be available for reimbursement are permanently forfeited.

Failure to submit the required supporting documentation and/or sign each claim form will delay the processing of your claim and may cause a denial of your claim.

For questions about the Reimbursement Program and help with filing claims, please contact ASO at (800) 537-1238.

Proof of Other Group Health Plan Coverage

If your other coverage is not through your City plan: you must submit the following items with your first claim of the year:

- Copy of your health insurance Identification ("ID") card; and
- Copy of a Summary of Benefits and Coverage ("SBC")

The above items must be submitted once per year to ensure that you are enrolled in an eligible group health plan and to determine your eligibility for reimbursement. If, after submitting your first claim, your coverage changes and you are issued a different health insurance card or SBC, you must submit updated copies of those items with any future claims.

You must also submit the following information in order to be eligible for reimbursement:

- Completed and signed claim form that describes the person(s) on whose behalf expenses have been incurred, a description of the expense incurred, the date the expense was incurred, and the amount of the requested reimbursement; and,
- A written statement from you that the expense has not been reimbursed and is not reimbursable under any other source; with either a
  - Copy of all EOBs for the expenses for which you are requesting reimbursement; or
  - Bills, invoices, or other statements from an independent third party (e.g., physician or other health care provider) showing that the Medical Care Expenses have been incurred and the amounts of such expense, together with any additional documentation that ASO may request.

No reimbursement will be made if such expenses have been reimbursed by any other health care insurance, plan, provider, or entity. If only a portion of an expense has been reimbursed elsewhere (e.g., because the other plan imposes copayments or deductibles), the Reimbursement Program can reimburse the remaining portion of such expense if it otherwise meets the requirements herein. Reimbursements are payable only to you, the participant; they are not payable to an insurance company or medical provider.

Reimbursements after Termination and COBRA

You will not be able to receive reimbursements for Medical Care Expenses incurred after your coverage terminates, unless you have not reached your annual maximum, in which case claims can be reimbursed after the date of termination until March 31 of the year following the year in which the expense was incurred.

Exclusions – Medical Expenses That Are Not Reimbursable

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

- Long-term care services and premiums for group health coverage paid with pre-tax dollars.
- "Cosmetic surgery" or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. Cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Babysitting and child care expenses.
- Funeral and burial expenses.
- Premiums for individual health insurance or Marketplace coverage.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).

- Massage therapy to improve general health.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons and swimming lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars.
- Over-the-Counter drugs and medicine.
- Any item that does not constitute "medical care" as defined under Code § 213.

In no event may the Reimbursement Program account reimburse premiums for individual health insurance, whether purchased in the individual insurance market or in a Health Insurance Marketplace.

Permanent Opting Out of the Reimbursement Program

If you wish to purchase a health plan from the Marketplace Exchanges, you will not be eligible for the Reimbursement Plan and must opt-out because, under the Patient Protection and Affordable Care Act (the "ACA"), Marketplace Exchange coverage does not constitute group health plan coverage that can be offered with a reimbursement account like the one the Fund provides. Accordingly, the ACA requires that the Fund provide an opportunity to permanently opt out and waive future reimbursements so that your eligibility for subsidies under the ACA is not affected.

You may request to opt-out of the Reimbursement Program and permanently forfeit your unused balance.

Contact the Fund Office for the HRA Permanent Opt-Out Form.

DENTAL BENEFITS

Limitations on Benefits

The following sections describe the Fund's Dental Benefits. The **Claims and Appeals Procedures; Appeals for Dental Benefits; Other Information You Should Know**; *and* **Your Rights Under the Employee Retirement Income Security Act of 1974** sections of this SPD, which start on page 48, describe how to appeal a denial of benefits, and the Fund's rules requiring that legal action following a denial of an appeal be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How the Dental Benefit Works

Dental benefits are administered by Self-Insured Dental Services, Inc. ("ASO/SIDS"). You have the option of going to any dentist or selecting from a panel of "participating dentists." However, whether you are treated by a participating or a non-participating dentist, all benefits are paid according to a "schedule of allowances" that provides a set fee for a particular procedure.

Dental benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act ("HIPAA") and the ACA as they are provided under a separate contract.

When you are treated by a participating dentist, your out-of-pocket expense for covered services, subject to Plan maximums and frequency limitations, is limited to the amount applied towards your individual calendar year deductible. Many diagnostic and preventive services that are not subject to the deductible are covered in full. See the "Schedule of Covered Dental Allowances" section for more information.

If you are treated by a non-participating dentist, your dentist will be reimbursed according to the Plan's Schedule of Covered Dental Allowances. If the non-participating dentist's fees are higher than the scheduled allowances, you are responsible for paying the difference.

This coverage is designed to encourage regular checkups and preventive care, and to correct minor dental problems before they become serious. Benefits are provided for diagnostic and preventive services, basic restorative services, major restorative services, bridges and dentures, periodontal treatment, oral surgical procedures, and orthodontic services. Basic and major dental services are subject to a **$100 annual deductible, and all dental services are subject to a maximum Fund payment of $2,500 per ACTIVE individual /$1,500 per RETIREE individual per calendar year**. You and your dependent Children are covered for orthodontic treatment up to a maximum of 24 months of treatment.

Individuals residing abroad. The Plan does not provide dental coverage for individuals residing outside the United States.

The following charts summarizes the procedures and costs covered.

OVERVIEW OF DENTAL COVERAGE
ANNUAL DEDUCTIBLE: $100 per covered individual per calendar year, applies to basic and major services. Deductible applies when using a PPO or Non-PPO provider
ANNUAL MAXIMUM: ACTIVE $2,500 per covered individual per calendar year
RETIREE $1,500 per covered individual per calendar year

PROCEDURES COVERED
DIAGNOSTIC AND PREVENTIVE SERVICES—routine procedures, such as oral examinations, bitewing X-rays and adult/child prophylaxis (cleaning).
BASIC SERVICES—common procedures, such as amalgam fillings, simple extractions and root canals.
MAJOR SERVICES—surgical extractions, periodontal treatment, gum surgery, crowns, inlays, fixed bridgework, removable dentures, and repairs to bridgework and dentures.
ORTHODONTIC SERVICES—correction of a handicapping malocclusion, including an initial examination insertion of appliance and monthly treatment visits.

Network of Participating Dentists

The Welfare Fund has contracted with ASO/SIDS to manage its own network of participating ("in-network") dentists. You choose the participating dentist who best suits the needs of you and your family. All participating dentists in the ASO/SIDS network have agreed to accept the Welfare Fund's Schedule of Covered Dental Allowances. That means that your dental benefit coverage will be the same no matter which participating dentist you choose.

THE DENTAL BENEFIT ADMINISTRATOR IS:

Administrative Services Only, Inc./
Self-Insured Dental Services ("ASO/SIDS")
P.O. Box 9005 Group 95
Lynbrook, NY 11563
Telephone: (800) 537-1238
Website: **http://www.asonet.com**

You save money when you and your family use dentists who are participating in the ASO/SIDS network. These dentists have agreed to accept the benefits provided under the Fund's Schedule of Covered Dental Allowances as payment in full (subject to any applicable deductibles). For information about participating providers in your area, contact ASO/SIDS at (800) 537-1238.

When you use a participating dentist, subject to Plan maximums and frequency limitations:

- Diagnostic and preventive dental services are covered in full in accordance with the Plan's schedule of maximum allowances; and
- Once you meet the deductible, basic and major restorative services are covered in full up to the Plan's maximum allowance.

If You Are Treated by a Non-Participating Dentist

If you are treated by a non-participating dentist, you or your dentist will be reimbursed according to the Fund's Schedule of Covered Dental Allowances. The charges of non-participating dentists are generally higher than the Plan's scheduled allowances, and **you are responsible for any difference between the amount a non-participating dentist charges and the amount the Fund will pay for covered services.**

Pre-Treatment Estimate

This process informs you and your dentist, in advance of treatment and before any expenses are incurred, what benefits are provided by the Plan.

It is recommended that a pre-treatment estimate be filed by your dentist if your dental care is going to cost more than $500 in a 90-day period or includes crowns, bridges, dentures, orthodontics, inlays or periodontal surgery.

> **Don't forget - Whether you go to a participating or a non-participating dentist, the Plan only pays up to the amount shown on the Schedule of Covered Dental Allowances.**

To obtain a pre-treatment estimate, ask your dentist to describe the treatment plan and expected charges on a claim form. X-ray charges should be included in a pre-treatment estimate for any proposed treatment involving root canal therapy, inlays, crowns, bridges, dentures, and periodontal surgery. Submit the completed claim form to:

> **Self-Insured Dental Services, Inc. ("ASO/SIDS")**
> P.O. Box 9005 Group 95
> Lynbrook, NY 11563

ASO/SIDS will review the proposed treatment and will provide you and your dentist with an explanation of benefits form. This form will indicate the benefit amount for each covered procedure and identify services that are not covered or not payable by the Fund.

The pre-treatment estimate is valid for one year from the date of its issuance, even if some or all of the work is done by another dentist. However, you must still be eligible for benefits when any of the approved services are rendered, and there must have been no significant change in your dental condition since the estimate was issued. Payment will be made in accordance with the applicable Plan allowances and limitations in effect at the time the covered services are completed.

Orthodontic Services

A dentist must diagnose the need for orthodontic services and must indicate that the orthodontic condition consists of a handicapping, abnormal, correctable malocclusion. Before treatment begins, ASO/SIDS should estimate the Plan allowance for orthodontic services under the pre-treatment estimate program.

Orthodontic services and benefits are described on the following chart.

ORTHODONTIC SERVICE	BENEFIT
Diagnosis and insertion of orthodontic appliances	$450 one-time payment
Active treatment, up to a maximum of 24 months	$50 per month
Retention treatment following active treatment, up to a maximum of 18 months	$100 per every six months

Orthodontic benefits are not subject to the annual deductible, nor do they count towards your annual maximum, but they are subject to the orthodontia lifetime maximum of 24 months of treatment.

Extension of Dental Benefits

If your or your dependents' eligibility terminates during the course of certain dental treatment, the patient's dental coverage will be extended for up to 90 days after eligibility would otherwise end so that the work can be completed. This limited extension applies to the following procedures only:

- Crowns, fixed bridgework and full or partial dentures—extension applies if impressions were taken and/or teeth were prepared while the patient was eligible;
- Orthodontic appliances and active treatment—extension applies if impressions were taken while the patient was eligible; or
- Root canal therapy—extension applies if the pulp chamber was opened while the patient was eligible.

There is no extension for any dental service other than those noted above.

Schedule of Covered Dental Allowances

The chart below lists all of the dental services covered by the Plan and the maximum benefit amount for each service. **Remember:** participating providers have agreed to accept the Plan's schedule of benefits as payment in full, subject to an annual $100 deductible per covered individual.

DIAGNOSTIC & PREVENTIVE	PLAN PAYS
ORAL EXAMINATION Maximum-two per calendar year	$15.00
FULL MOUTH SERIES X-RAYS 10 to 14 periapical/bitewing films	$30.00
PANORAMIC FILM	$30.00
PERIAPICAL OR BITEWING, per film	$4.00
OCCLUSAL FILM	$13.00
CEPHALOMETRIC FILM	$34.00
POSTERIOR-ANTERIOR FILM	$32.00
LATERAL FILM	$32.00
TEMPOROMANDIBULAR FILM X-ray maximum-$50 per calendar year	$40.00

PROPHYLAXIS Including scaling and polishing; maximum two per calendar year	
Adult	$28.00
Child, to age 15	$25.00
FLUORIDE TREATMENT Excluding prophylaxis to age 15, two per calendar year	$18.00
SEALANT Unrestored permanent posterior teeth only, to age 15. Lifetime maximum - $45 per quadrant	$15.00
SPACE MAINTAINER	
Removable	$98.00
Fixed	$135.00
BASIC RESTORATIVE	
AMALGAM FILLINGS	
One surface	$35.00
Two surfaces	$45.00
Three surfaces	$55.00
Four or more surfaces	$65.00
COMPOSITE RESIN-ANTERIOR	
One surface	$35.00
Two surfaces	$45.00
Three surfaces	$60.00
Four or more and incisal angle	$60.00
COMPOSITE RESIN-POSTERIOR	
One surface	$40.00
Two surfaces	$50.00
Three surfaces	$60.00
MAJOR RESTORATIVE Pre-operative periapical X-ray required. There is a five-year frequency limitation on replacements.	
CROWNS-RESIN	$120.00
Resin with metal	$325.00
Porcelain	$325.00
Porcelain with metal	$375.00
Full cast with metal	$350.00
METALLIC INLAY	
One surface	$200.00
Two surfaces	$250.00
Three surfaces	$300.00
PORCELAIN INLAY	
One surface	$200.00

Two surfaces	$250.00
Three surfaces	$300.00
STAINLESS STEEL CROWN (Primary tooth)	$100.00
CAST POST & CORE	$100.00
PREFAB POST AND CORE	$86.00
ENDODONTICS X-ray evidence of satisfactory completion required.	
PULPOTOMY	$75.00
ROOT THERAPY	
Anterior	$200.00
Bicuspid	$250.00
Molar	$325.00
APICOECTOMY	$130.00
APICOECTOMY Maximum per tooth	$260.00
RETROGRADE FILLING	$60.00
PROSTHODONTICS Preoperative X-rays are required when filing a claim for pre-treatment review or payment on all prosthetics. X-rays of the full arch must be included for all bridgework. There is a five-year frequency limitation from date of installation on all prosthetics.	
COMPLETE DENTURE Immediate or permanent	$400.00
PARTIAL DENTURE – UNILATERAL	$340.00
PARTIAL DENTURE – BILATERAL Acrylic base with clasps and rests	$325.00
Cast metal base	$400.00
PRECISION ATTACHMENT	$100.00
BRIDGE PONTIC Full cast	$300.00
Resin with metal	$300.00
Porcelain with metal	$375.00
ABUTMENT – INLAY TWO SURFACES	$250.00
ABUTMENT – INLAY THREE SURFACES	$300.00
CAST METAL RETAINER-ACID ETCH BRIDGE	$200.00
BRIDGE ABUTMENT Crown-resin with metal	$325.00
Crown-porcelain fused to metal	$375.00
Crown-full cast	$300.00
Crown repair	$100.00
DENTURE RELINE COMPLETE or PARTIAL – CHAIRSIDE	$80.00
DENTURE RELINE-PARTIAL – LABORATORY	$100.00
DENTURE RELINE-COMPLETE – LABORATORY	$125.00

DENTURE REPAIRS Denture adjustment	$25.00
Repair cast framework	$95.00
Repair resin denture base	$70.00
Replace tooth in denture	$65.00
Add tooth to existing partial denture	$65.00
RECEMENT CROWN OR INLAY	$25.00
RECEMENT BRIDGE	$30.00
BRIDGE REPAIR BY REPORT	$100.00

	PLAN ALLOWANCE	CO-PAY
Endosteal Implant	$1,200.00	$0.00
Subperiosteal Implant	$1,200.00	$0.00
Transosseous Implant	$1,200.00	$0.00
Prefabricated Abutment	$200.00	$275.00
Custom Abutment	$200.00	$275.00
Abutment Supported Porcelain Ceramic Crown	$375.00	$300.00
Abutment Supported Porcelain/Metal Crown	$375.00	$300.00
Abutment Supported Crown	$375.00	$300.00
Abutment Supported Cast High Noble Metal Crown	$375.00	$300.00
Abutment Supported Noble Metal Crown	$375.00	$225.00
Implant Supported Porcelain Ceramic Crown	$375.00	$600.00
Implant Supported Porcelain/High Noble Metal Crown	$375.00	$600.00
Implant Supported High Noble Metal Crown	$375.00	$600.00

PERIODONTIC SERVICES

Although eight teeth constitute the anatomic complement of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.

SCALING AND ROOT PLANING, INCLUDING PROPHYLAXIS Per quadrant; maximum allowance on any combination of the below services is $200 in a calendar year	$50.00
Two or more quadrants per visit	$75.00
Periodontal maintenance	$60.00
FULL MOUTH DEBRIDEMENT	$75.00

PERIODONTAL SURGERY

Confirmation by charting and/or X-rays required per quadrant of at least 5 teeth

Localized delivery of chemotherapeutic agent maximum allowance $150 per quadrant	$50.00
Gingivectomy, gingivoplasty and mucogingival surgery per quadrant	$150.00

Osseous surgery, including gingivectomy-per quad osseous graft, per quadrant	$375.00 $75.00
PEDICLE or FREE SOFT TISSUE GRAFTS	$200.00
ORAL SURGERY	
ROUTINE EXTRACTION	$40.00
SURGICAL EXTRACTION Must be demonstrated by x-ray	
Erupted tooth	$65.00
Removal of residual roots	$90.00
Impaction-soft tissue	$100.00
Impaction-partial bony	$175.00
Impaction-complete bony	$200.00
ALVEOLOPLASTY – PER QUAD	$125.00
BIOPSY OF ORAL TISSUE – HARD TISSUE	$100.00
SURG.EXP-IMP/UNERUP(FOR ORTHO)	$175.00
SURG.EXP-IMP/UNERUP(AID ERUPT)	$125.00
REMOVAL OF CYST OR TUMOR- <1.25	$75.00
REMOVAL OF CYST OR TUMOR- >1.25	$100.00
FRENULECTOMY	$95.00
ORTHODONTICS	
INITIAL FIXED APPLIANCE	$450.00
ACTIVE TREATMENT – PER MONTH Maximum of 24 months	$50.00
POST-TREATMENT STABILIZATION DEVICE	$110.00
PASSIVE TREATMENT – PER 6 MONTHS Maximum of 18 months	$100.00
MINOR TOOTH MOVEMENT	
Removable appliance	$225.00
Fixed appliance	$225.00
ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT No other treatment than visit	$30.00
GENERAL ANESTHESIA-per 15 minutes Plan pays first 30 minutes only	$55.00
OCCLUSAL GUARD	$225.00
SPECIALIST CONSULTATION Includes examination	$50.00
BEHAVIOR MANAGEMENT Only when rendered by a participating pedodontist in conjunction with other treatment	$50.00

TOOTH WHITENING – PER ARCH Must be provided by a licensed dentist using materials and equipment specifically designed to accomplish tooth whitening in a one-visit chairside setting on natural unrestored teeth. All other tooth whitening products or take-home method, including those provided by a dentist, are not covered. Lifetime maximum – one treatment per arch	$150.00

How to File a Dental Claim

Participating Dentist. You do not have to pay a participating dentist any money for covered services other than the deductible, if applicable, and you do not have to file a claim. The dentist's office will file the claim form. You are expected to assign benefits on the claim form so that the participating dentist can be paid directly by ASO/SIDS.

Non-Participating Dentist. When you are treated by a dentist who is not a participating provider, you or your dentist should file a claim form with ASO/SIDS. Claim forms are available from ASO/SIDS or the Fund Office. You are responsible for the difference between your dentist's charges and the maximum benefit amount listed in the Plan's Schedule of Covered Dental Allowances.

All claim forms, whether the services are provided by a participating or a non-participating dentist, should be sent to:

Administrative Services Only, Inc.
Self-Insured Dental Services ("ASO/SIDS")
P.O. Box 9005 Group 95
Lynbrook, NY 11563

See the section called "**Claims and Appeals Procedures**" for additional information on filing claims and appeals of denials of claims.

Exclusions and Limitations

There is no coverage for:

- Any charges that exceed the amounts shown in the Schedule of Covered Dental Allowances;
- Treatment for the purpose of cosmetic improvement;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown, inlay or denture within five years after the date it was originally installed;
- Any replacement of a bridge, crown, inlay or denture which can be made usable according to accepted dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to:
  - Change vertical dimension; or
  - Diagnose or treat conditions or dysfunctions of the temporomandibular joint;

- Stabilize periodontally involved teeth;
- Periodontal splinting;
- Multiple bridge abutments;
- Over-the-counter analgesia;
- Services that do not meet accepted dental standards;
- Services not specifically included in the Schedule of Covered Dental Allowances;
- Services or supplies resulting from an accidental Injury, which are deemed to be the responsibility of a third party;
- Any care that is covered under Workers' Compensation or a similar law, or for an Injury arising out of, or in the course of, any employment for wage or profit;
- Charges made by a Veterans Administration ("VA") facility for a service-related Illness or Injury;
- Services for which payment is unlawful where the person resides when the expenses are incurred;
- Services for which there would be no charge in the absence of this coverage, including services provided by a member of the patient's immediate family;
- Charges for unnecessary care, treatment or surgery;
- Any charges that are paid for by a government program; and
- Experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Important Definitions

Dentist – A person who is licensed to practice dentistry in the state where the service is provided.

Necessary treatment – A procedure, service or supply that is required or appropriate for the treatment of your dental condition according to generally accepted standards of care.

Non-participating dentist – A dentist who does not have an agreement with ASO/SIDS to accept the Fund's maximum allowance as payment in full for covered services.

VISION BENEFITS

Limitations on Benefits

The following sections describe the Fund's vision benefits. The **Claims and Appeals Procedures; Appeals for Vision Benefits; Other Information You Should Know**; *and* **Your Rights Under the Employee Retirement Income Security Act of 1974** sections of this SPD, which start on page 48, describe how to appeal a denial of benefits, and the Fund's rules requiring that legal action following a denial of an appeal be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How the Vision Benefit Works

Vision benefits are provided through two networks of Providers—Comprehensive Professional Systems ("CPS"), (212) 675-5745, and General Vision Services ("GVS"), (800) 847-4661. You may use either network, or you may use a non-network Provider. Selections of frames and lenses may vary among the two networks and, in some instances, among locations in the same network.

You can obtain a list of Participating Providers from the Fund Office at (800) 529-3863.

Vision benefits are treated as a stand-alone (or excepted) benefit under HIPAA and the ACA. You may decline vision benefits. See the **"Enrolling for Coverage"** section for details if you wish to decline vision benefits.

Benefits

If you are eligible for Vision benefits, you and your covered dependents are each entitled to an eye examination and new glasses or contact lenses once every 365 days. The 365-day limit is strictly enforced. If you are not certain when you last received Vision benefits, you should contact the Fund Office. If you receive benefits before 365 days have elapsed since you last received Vision benefits, your claim will be denied.

If you use a Participating Provider, there are no out-of-pocket costs if the frames and lenses you select are part of the program. If the frames and lenses you select are outside the program, you will receive a credit towards your purchase.

Individuals residing abroad. The Plan **does not** provide vision coverage for individuals residing outside the United States.

Covered Services

In general, the Fund will pay a Participating Provider a total of $125 for an eye examination ($25) and a pair of frames and/or lenses ($100). If you use a Non-Participating Provider, the Fund will reimburse you up to $125 for the same services.

Vision Costs

Some services from Participating Providers require that you pay a portion of the cost. These services and their applicable costs are listed below. If you receive any of these services from a Non-Network Provider, you will be responsible for any cost above your $125 allowance.

SERVICE TYPE	YOUR COST AT CPS	YOUR COST AT GVS
Scratch-resistant coating, single vision	$10	$10
Scratch-resistant coating, bifocal or trifocal	$15	$15
High-index single vision plastic lenses	$50	No charge
High-index bifocal plastic lenses	$70	No charge
Polycarbonate single vision lenses	$30	$70
Polycarbonate bifocal lenses	$70	$100
Reflection-free coating	$40	$40
Transition single vision lenses	$75	$75
Transition bifocal/multifocal lenses	$100	$100
Hyper-index	$125	$125

How to File a Vision Claim

Network Provider. All you have to do is provide your name and Social Security Number to the Network Provider. The Provider will submit the claim form to the Fund Office for payment. If you receive any of the services described under "Costs" (shown above), you will also be required to pay your share of the cost.

Non-Network Provider. When you use a Provider who is not participating in the CPS or GVS network, you must pay the full cost and submit a claim to the Fund Office for reimbursement. The Fund will reimburse you up to the amount it would have paid had you gone to a Participating Provider (up to $125 for an eye examination and a pair of frames and/or lenses).

HEARING BENEFITS

Limitations on Benefits

The following sections describe the Hearing Benefits available under the Fund. The **Claims and Appeals Procedures; Appeals for Hearing Benefits; Other Information You Should Know**; *and* **Your Rights Under the Employee Retirement Income Security Act of 1974** sections of this SPD, starting on page 48, describe how you can appeal a denial of benefits and the Fund's rules requiring that legal action following a denial of an appeal must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

Covered Services

You and your covered dependents are eligible for a hearing benefit once every four (4) years. Although you may receive benefits from any hearing Provider, you will receive the highest level of coverage when you use the network of Participating Providers affiliated with Comprehensive Professional Systems ("CPS") or General Hearing Services ("GHS").

You may obtain benefits at any Provider with whom GHS and CPS have negotiated discounts on your behalf. For a listing of Participating Providers, call: GHS at (800) 847-4661 or CPS at (212) 675-5745. Coverage is provided at no cost to you from a CPS Provider and for a $150 Copayment at a GHS Provider for the following:

- A hearing evaluation;
- Behind the ear, all-in-the canal, completely-in-the-canal and digital, programming hearing aids;
- A battery for your hearing aid, with a one-year guarantee;
- At CPS only the ear impression (ear mold) is also covered; and
- Unlimited repair services of your hearing aid for one year.

If you select a hearing aid that is not part of the Fund package, you may have additional out-of-pocket costs which are not eligible for reimbursement.

When you use a Non-Network Provider, you will have to pay for the services you receive and submit a claim to the Fund Office. The Fund will reimburse you the same benefit amount it would have paid if you had gone to a Network Provider (maximum benefit of $350 for each ear, once every four (4) years). This hearing benefit is available to all eligible family members.

How to File a Hearing Claim

Network Provider. All you have to do is provide your name and Social Security number to the Provider who will submit the claim form to the Fund Office for payment.

Non-Network Provider. When you use a Provider who is not in the CPS or GHS networks, you must pay the full cost and submit an itemized receipt to the Fund Office for reimbursement. Be sure to keep a copy of the itemized receipt for your own records.

COORDINATION OF BENEFITS

You or your family members may have other health care coverage. In this case, the two health coverage programs will coordinate their benefit payments so that payments from the two plans combined will pay up to the amount of covered expenses, but not more than the amount of actual expenses.

When you are covered under two plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

Which Plan Pays Benefits First?

Here is how we determine which plan has primary responsibility for paying benefits:

- If the other plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered by one plan as an Active Employee and by another plan as a laid-off or former employee or Retiree, the plan that covers you as an Active Employee is primary.
- If you are covered by one plan as an employee and by the other plan as a dependent, the plan that covers you as an employee is primary.

For a dependent Child covered under both parents' plans, the primary plan is:

- The plan of the parent whose birthday comes earlier in the calendar year (month and day);
- The plan that has covered the parent for a longer period of time, if the parents have the same birthday, or
- The father's plan, if the other plan does not follow the birthday rule and uses gender to determine primary responsibility.

When the parents are divorced or separated:

- If there is no court decree establishing financial responsibility for the Child's health care expenses, the plan covering the parent with custody is primary.
- If the parent with custody is remarried, his/her plan pays first, then the step-parent's plan pays second, and the non-custodial parent pays third.
- If there is a court decree specifying which parent has financial responsibility for the Child's health care expenses, that parent's plan is primary once the Fund Office has written notice of the decree.

If none of the previous rules apply, the plan that has covered the parent longest is primary.

If This Plan is the Secondary Plan

If this Plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. The Plan will not pay more than the amount it would normally pay if it were primary.

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claims under each plan.
- File claims first with the primary plan, then with the secondary plan
- Include the original or a copy of the EOB from the primary plan when you submit your bill to the secondary plan. Keep a copy for your records.
- You are required to provide information about other health care coverage you or members of your family may have upon request by the Fund Office or one of the Plan's claims administrators. If you fail to notify the Fund Office or claims administrators of other group health coverage for you or your dependents that would otherwise have primary liability for claims, or should you fail to respond to a coordination of benefits inquiry from the Fund Office or claims administrators, coverage for you and your family will be suspended.

LIFE INSURANCE

Limitations on Benefits

The following sections describe the Life Insurance Benefits available under the Fund. The **Claims and Appeals Procedures; Appeals for Life Insurance Benefits; Other Information You Should Know;** *and* **Your Rights Under the Employee Retirement Income Security Act of 1974** sections of this SPD, starting on page 48, describe how you can appeal a denial of benefits and the Fund's rules requiring that legal action following a denial of an appeal must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How the Life Insurance Benefit Works

The Fund provides basic life insurance benefits at no cost to you through an insurance company (for contact information, see the chart on page 2).

If you die while you are an Active Employee, your **Beneficiary** will receive a life insurance payment of $25,000 (less any accelerated death benefit paid, as described later)

If you are an eligible Retiree, your **Beneficiary** will receive a life insurance payment of $6,000.

Please contact the Fund Office for more information about your Life Insurance benefit.

Naming a Beneficiary

You must name a Beneficiary for your life insurance benefit. Your Beneficiary may be one or more person(s), a trust, an estate, a charity, etc. You can also designate a contingent Beneficiary to receive benefits if your primary Beneficiary dies before you.

You may change your Beneficiary at any time by submitting a new Beneficiary designation form to the Fund Office. A change in Beneficiary is not effective unless and until it is received by the Fund Office. Beneficiary designation forms are available from the Fund Office and may be downloaded from the Fund Office website at **www.nyccbf.org**. It is important to keep your Beneficiary designation up to date. You should review your Beneficiary designation when circumstances in your life change (e.g., marriage, divorce, birth or adoption of a Child, death). A divorce or a termination of a domestic partnership **does not** change your Beneficiary or invalidate your prior designation of your former spouse or domestic partner as Beneficiary for your benefit. If you are divorced or experience another life event and wish to change your Beneficiary, you must submit a new Beneficiary designation form to the Fund Office.

If you do not name a Beneficiary, or if your Beneficiary dies before you, your life insurance benefit will be paid to:

- Your surviving spouse or, if none,
- Your Children in equal shares or, if none,

- Your parents in equal shares or, if none,
- Your brothers and sisters in equal shares or, if none,
- Your estate.

Accelerated Death Benefit for Terminally Ill Active Employees Only

If you are an Active Employee, you may elect to have an Accelerated Benefit amount of a minimum of $3,000 and a maximum of $12,500 (but the amount cannot exceed 50% of your life insurance benefits) paid to you while you are still living if:

- Your life expectancy is six months or less; and
- You are insured for at least $10,000.

The accelerated death benefit is payable to you in a single lump sum, once in your lifetime. Upon your death, the life insurance benefit paid to your Beneficiary will be reduced by the benefits you received under the accelerated death benefit.

To apply for an accelerated death benefit, send a written request to the Fund Office. The insurance company will require a doctor's written certification that you are terminally ill with a life expectancy of six months or less and may require an independent exam.

If you are required by law to accelerate benefits to meet the claims of creditors, or a government agency requires you to apply for benefits to qualify for a government benefit or entitlement, you will still be required to satisfy all the above requirements in order to receive an Accelerated Benefit

Converting to an Individual Policy

If your life insurance benefit from the Fund ends, you may convert all or a portion of your coverage to an individual policy. You must apply for an individual policy within 31 days after your Fund coverage ends. To apply for conversion coverage, contact the Fund Office.

You may not be turned down for an individual policy when you convert your life insurance within 31 days, even if you are in poor health. You will not be required to have a medical examination if you apply to convert your coverage within 31 days.

How to File a Life Insurance Claim

Your Beneficiary or a family member should contact the Fund Office within 30 days of your death to obtain a claim form. A Fund Office representative will provide any necessary forms within 15 days. If the forms are not provided within 15 days, you may submit any other written proof that describes the nature and extent of your claim. In addition to completing a claim form, your Beneficiary will be asked to provide an original death certificate as proof of death.

A completed claim form and proof of loss must be submitted to the Fund Office as soon as possible after a covered loss.

SHORT-TERM DISABILITY

How the Plan Works

This Plan will pay Active Employees a weekly benefit if you become disabled and unable to work as the result of an Injury or Illness that is not work-related. There is no short-term disability insurance for dependents or retirees (except retirees who return to work in Covered Employment, become Active Employees again, and then are disabled as a result of Injury or Illness that is not work-related).

To receive disability benefits, you must be under the care of a physician and he/she must certify to the Fund that you are disabled. Weekly benefits for pregnancy will be provided in the same manner as benefits for an "Illness."

Note: If you receive short-term disability benefits from the Plan and participate in the New York City District Council of Carpenters Pension Plan (the "Pension Plan"), you may be ineligible to receive monthly pension payments from the Pension Plan for the period of time that you receive short-term disability benefits. Contact the Pension Plan to determine how your monthly pension benefit could be affected if you receive short-term disability benefits.

When Coverage Begins

You are covered for short-term disability benefits whenever you are working in Covered Employment.

When Short-Term Disability Benefits Begin

Your weekly benefit will begin on the first day of a disability resulting from an Injury or the eighth day of a disability resulting from Illness. Benefits are payable as long as you remain disabled, for up to a maximum of 26 weeks of disability in any 52-week period.

Your Short-Term Disability Benefits

Your weekly benefit is 50% of your average weekly earnings (as defined by state law) at the time you became disabled, up to a maximum benefit of $400 per week. If your disability occurs while you are actively employed or within 28 days of your last day worked, the Fund will pay you short-term disability benefits.

How to File a Short-Term Disability Claim

Call the Fund Office toll-free at (800) 529-3863 or visit the Fund's website at **www.nyccbf.org** to obtain a claim form as soon as you stop working. Return the completed form to the Fund Office. Keep a copy of your claim form for your records. The Fund reserves the right to ask for evidence of continued disability at any time.

Please note that because the Fund relies on your physician's certification of disability, and the Fund does not make its own determination of disability for short-term disability benefits, short-term disability claims and appeals are not subject to the United States Department of Labor's Benefit Claims Procedure Regulation.

Work-Related Disabilities

The Fund **does not** pay short-term disability benefits for Injuries or Illnesses arising out of or in the course of your employment.

SCHOLARSHIP AND RECOGNITION PROGRAM

The Fund offers a Scholarship and Recognition Program for unmarried dependent biological or adopted Children of eligible participants. For purposes of the Scholarship and Recognition Program, these Children are referred to as "Qualifying Children." International Scholarship and Tuition Services ("ISTS"), an independent and professional organization, administers the Scholarship and Recognition Program.

Eligibility

Your Child's eligibility for this benefit depends, first, on your eligibility. You are eligible if you meet the eligibility requirements below:

- You are working for or have worked for an employer who is obligated to make contributions to the Welfare Fund on your behalf, which is referred to as "Covered Employment;" and
- You worked at least 4,000 hours in Covered Employment in the five calendar years ending on the December 31 prior to the September for which the scholarship is awarded (and you worked at least 600 hours in each of four of those five calendar years); or
- You worked at least 6,000 hours in Covered Employment in the seven calendar years ending on the December 31 prior to the September for which the scholarship is awarded (and you worked at least 500 hours in each of five of those seven calendar years).

If you are receiving short-term disability benefits from the Welfare Fund, Workers' Compensation or state unemployment benefits, you will receive credit for seven hours worked for each day that you receive these benefits. (Proof must be submitted.)

How the Scholarship Plan Works

This benefit is a scholarship program for unmarried, dependent Children, including biological, stepchildren (claimed as a dependent on income tax forms) or legally adopted Children, regardless of age who:

- Are entering college as freshmen without prior college credit; or
- Are entering college with prior college credit earned while completing high school (in an early admissions placement program or advanced placement program); or
- Are mid-year graduates who entered college prior to the academic year beginning in September; when a scholarship would first be payable, and who earned one-half year of college credit.

If you are a Retiree, your Qualifying Children are eligible for this program if you met the above-described scholarship eligibility requirements as of the date of your retirement.

Qualifying Children of deceased participants are eligible if the participant had met the above-described scholarship eligibility requirements at the time of death.

The Scholarship and Recognition Program is not available for post-graduate work.

The Benefit

The Fund provides Charles Johnson Jr. Memorial Scholarships that pay up to $3,500 for each year of a four-year academic program at an accredited college or university, or until the Child receives a bachelor's degree, whichever occurs first. The maximum amount of the award is $14,000 per student.

The $3,500 annual award must be used within four years from the initial award of the scholarship. However, if a recipient takes a leave of absence from his/her academic program for good cause, as determined in the sole discretion of the Board of Trustees, or designated committee thereof, the Trustees have the discretion on an appeal to grant the remainder of a scholarship after the recipient resumes his/her academic program following the leave of absence. Please see page 53 for information concerning appeals to the Trustees.

Any other financial assistance (e.g., awards from other sources including Local Unions, aid, loans) received by your Child must be reported to the Scholarship and Recognition Program. The Scholarship and Recognition Program adjusts the scholarship so that the combination of financial assistance and the award do not exceed total tuition, room, board, book expenses, and usual fees. New York State Regents awards, however, are not taken into consideration. This benefit is paid directly to the educational institution, and not to you or your Child.

If your Child wins a scholarship award from a Local Union affiliated with the District Council which exceeds the Fund's benefit, your Child will be eliminated from the Fund's competition.

How to Apply

The application process begins during the student's senior year of high school. You should review the special Scholarship and Recognition Program eligibility rules at the beginning of this section and your work history in Covered Employment.

Participant eligibility will be reviewed after all applications have been submitted and evaluated. Children who do not meet the eligibility requirements will be eliminated from the competition.

All applications and supporting materials must be submitted online. There are no paper applications. Your Child must register online at **https://aim.applyists.net/NYCDCC** and follow all instructions and procedures.

Your Child must take the College Board SAT Reasoning Test by December and upload a copy of his/her SAT scores using the drop-down menu on the academic page of the online application by December 15th. Applications received after the due date will not be accepted.

Questions concerning the online application should be directed to ISTS at (855) 670-4787.

Selection Process

ISTS considers a number of factors in awarding scholarships: the student's high school academic record, SAT scores, moral character, leadership qualities, seriousness of purpose, extracurricular activities, writing samples from the applicant, and letters of recommendation. The ISTS decision is final. The number of scholarships awarded is in the Trustees' sole discretion.

CONFIDENTIALITY

Permitted Uses and Disclosures of PHI by the Fund and the Board of Trustees

The Welfare Fund operates in accordance with HIPAA. A complete description of your rights under HIPAA is available in the Fund's Notice of Privacy Practices. The following statement is a summary of the key provisions of the Fund's Notice of Privacy Practices.

The term "Protected Health Information" ("PHI") includes all individually identifiable health information related to your past, present or future physical or mental condition or payment for health care. PHI includes all information maintained by the Fund in oral, written or electronic form (except for any information that is received in connection with life insurance or disability benefits). While these items are not PHI under HIPAA, the Fund Office generally treats them as confidential and will not disclose the information without consent, or as required by law or as necessary in connection with claims for life insurance benefits in which case a beneficiary designation may be disclosed to an individual applying for life insurance benefits.

The Fund and the Trustees are permitted to use and disclose PHI to the extent such disclosures comply with HIPAA, in very limited circumstances and when the following safeguards are in place to protect your privacy:

- The Fund will disclose PHI to the Trustees only for the Trustees' use in Plan administration functions, unless the Trustees have your written permission to use or disclose your PHI for other purposes;
- The Fund has in place safeguards to protect the confidentiality, security and integrity of your health information. PHI that is received by the Trustees from the Fund will not be used or disclosed other than as permitted or required by this SPD, or as required by law, or at the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Fund;
- The Trustees will not disclose your PHI to any of its Providers, agents or subcontractors unless the Providers, agents and subcontractors agree to keep your PHI confidential to the same extent as it is required of the Trustees;
- The Fund may disclose PHI to external vendors for purposes of health care management in accordance with appropriate confidentiality agreements. Data shared with external entities for measurement purposes or research will be released only in an aggregate form that does not allow direct or indirect participant identification. Identifiable personal information may not be shared with the Fund Office, unless required by law;
- The Trustees will report to the Fund's Privacy Officer any use or disclosure of PHI that is inconsistent with the Fund's Privacy Policy;
- The Fund will allow you to inspect and photocopy your PHI to the extent, and in the manner, required by HIPAA;

- The Fund will make available your PHI for amendment and incorporation of any such amendments to the extent and in the manner required by HIPAA;
- The Fund will keep a written record of certain types of disclosures it may make of PHI, so that the Fund can maintain an accounting of disclosures of PHI;
- The Fund will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Fund in order to allow the Secretary to determine the Fund's compliance with HIPAA;
- The Trustees will return to the Fund or destroy all PHI received from the Fund when there is no longer a need for the information. If it is not feasible for the Trustees to return or destroy the PHI, then the Trustees shall limit their further use or disclosures of any of your PHI that they cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible;
- The Fund shall ensure that adequate separation will be maintained within the Fund. Only the categories of employees enumerated hereafter and Trustees will be permitted to have access to and use the PHI to perform Plan administrative functions. The following categories of employees under the control of the Trustees are the only employees who may obtain PHI in the course of performing the duties of their job with or on behalf of the Trustees: The Executive Director, the Chief Financial Officer, the Director of Welfare and Eligibility, and all other Welfare Fund staff routinely responsible for administration of claims for the Fund. Additionally, Trustees may receive health information from the Fund in the course of hearing appeals or handling other Plan administration functions;
- If we become aware of any noncompliance with the provisions outlined above by any of the individuals listed above, we will promptly report the violation to the Fund's Privacy Officer and will cooperate to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to the individual(s) whose privacy has been violated; and
- You will receive notice if a breach of your PHI occurs.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits and the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. The procedures will vary depending on the type of your claim. The Welfare Fund has contracted with a number of claims administrators ("Claims Administrator") to administer the different benefits. Read each of the following sections carefully to determine which procedure is applicable to your particular request for benefits.

What Is a Claim

A claim is a request for benefits made in accordance with the Fund's claims procedures.

What Is Not a Claim

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself/herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a claim is denied due to lack of eligibility, it is treated as an adverse benefit determination and you will be notified of the decision and allowed to file an appeal; or
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's in-network vision provider(s). After the denial, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks supporting documents, you will be notified about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

How to File a Claim

A claim form may be obtained from the Fund Office by calling (800) 529-3863 or from the Claims Administrator listed on pages 49-50. The claim form should be completed in its entirety and submitted to the Claims Administrator. If a request is filed improperly or the form is incomplete, the request will not constitute a claim under these procedures.

You will only receive notice of an improperly filed claim if the claim includes (i) your name, (ii) your specific medical condition or symptom and (iii) a specific treatment, service or product for which

approval is requested. Check the claim form to be certain that all applicable portions of the form are completed. Include with the claim form any **Itemized Bills** if services have already been provided to you or any documentation requested to verify your claim. If the claim forms have to be returned to you for information, delays in processing the claim will result.

A claim form that is incorrectly sent to the Fund Office will be redirected to the Claims Administrator. The applicable time frame for processing the claim will begin to run from the date the claim is received at the Claims Administrator (discussed further below in **When Claims Must Be Filed**).

Authorized Representatives

An authorized representative, such as your spouse or adult child, may complete the claim form for you if you have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. If an authorized representative is designated, all notices will be provided to you through your authorized representative. The Fund **does not** permit providers, hospitals or facilities to act as your Authorized Representative.

When Claims Must Be Filed

All claims, except life insurance claims, **must be** filed in writing by no later than 365 days (one year) after the date the charges were incurred. Life insurance claims must be filed in writing no later than 730 days (two years) after the date of death. In all circumstances, claims should be filed in writing as soon as possible after the date the charges are incurred. Your claim will be considered to have been filed as soon as it is received by the Claims Administrator that is responsible for making the initial determination of the claim.

Claims Administrator - Where to Submit Your Initial Claim

When you receive dental and vision services from an In-Network or Participating Provider, the Provider will submit a claim on your behalf. When you incur expenses for these services from an Out-of-Network or Non-Participating Provider, **you** are responsible for submitting a claim form to the Claims Administrator listed below:

Dental and Reimbursement Program claims must be submitted to:

Administrative Services Only, Inc. ("ASO/SIDS")
P.O. Box 9005 Group 95
Lynbrook, NY 11563
Telephone: 800-537-1238
Website: **http://www.asonet.com**

Out-of-network vision, hearing, disability, and life insurance claims must be submitted to:

New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014
800-529-3863

The Fund Office will review life insurance claims for eligibility and completeness and then forward the claim to:

Amalgamated Life Insurance Company
Attn: Policy Services
333 Westchester Avenue, N101
White Plains, NY 10604-2910

Time Frames for Decision-Making

The Fund's procedures and time limits for evaluating claims and informing you of the decision will vary depending upon the type of claim.

The Plan does not require prior approval for any benefits (although you are encouraged to obtain pre-treatment estimates for certain dental benefits); thus, there are no Pre-Service or Urgent Claims under this Plan, but only Post-Service claims. Post-Service claims are claims for benefits where the services have already been provided. A request to reimburse you for a dentist visit or the purchase of a hearing aid are examples of Post-Service claims.

Post-Service Claims. Post-Service claims will be decided no later than 30 days after the Claims Administrator receives your claim. You will be notified in writing within the 30-day initial determination period if the claim is denied (in whole or in part).

If a claim cannot be processed due to insufficient information, you will be notified in writing about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended until the earlier of 45 days or until the date of receipt of your written response to the request for information. The Claims Administrator then has 15 days to make a decision and notify you in writing.

Disability Claims. Disability claims will be decided no later than 45 days after the Fund receives the claim. If the Fund has to extend the time frame for an additional 30 days, it will inform you it needs additional time before the end of the initial 45-day period. If the Fund requests additional information from you, you will have at least 45 days to provide it. The Fund will make a decision on your claim within 30 days after you provide the additional information requested. The Fund may extend the time period for deciding your claim for another 30 days so long as it notifies you before the first 30-day extension expires. The Fund needs your consent for any further extension beyond the two 30-day extensions noted above.

Life Insurance Claims. Generally, you will receive written notice of a decision on your claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator), you will be notified in writing within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). A denial of a claim also includes any claim where the Fund pays less than the total amount of expenses submitted. The notice of adverse determination will:

- Identify the claim involved (e.g., date of service, provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's appeal process along with time limits and information about how to initiate an appeal; and
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal.

If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request. If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request.

Appeal Process

If a claim is denied (in whole or in part) and you disagree with the decision, you or your authorized representative may appeal. The amount of time you have to appeal, and levels of appeal are summarized in the following chart:

TYPE OF BENEFIT	WHERE TO SEND APPEAL	ALLOWABLE AMOUNT OF TIME TO SUBMIT APPEAL
Dental	**First Level** - ASO/SIDS **Voluntary Second Level** - Appeals Committee of the Board of Trustees ("Appeals Committee")	**First Level** - Within 180 days of notice of adverse benefit determination **Voluntary Second Level** - Within **60** days of notice of denial of First Level Appeal
Life Insurance	Appeals Committee	Within **180** days of notice of adverse benefit determination
Reimbursement Program	Appeals Committee	Within **180** days of notice of adverse benefit determination
Short-Term Disability, Vision, Hearing	Appeals Committee	Within **180** days of notice of adverse benefit determination

Dental Appeals:

Self-Insured Dental Services, Inc. ("ASO/SIDS")
P.O. Box 9005
Lynbrook, NY 11563
Telephone: 800-537-1238
Website: **http://www.asonet.com**

Life Insurance Appeals:

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

Short-Term Disability, Reimbursement Program, Vision, and Hearing Appeals:

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

Your Rights in the Appeal Process

Your Rights in the Review Process

- You have the right to review, free of charge, documents, records or other information relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.
- The appeal will be reviewed by an appropriate named fiduciary who is not the individual who initially denied your claim (or the first appeal decision in cases with more than one level of appeal).
- The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional written documents, records and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.
- The health care professional shall be an individual who is neither the individual who was consulted in connection with your original claim or first level appeal, or the subordinate of such individual.
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

Appeals Heard by the Board of Trustees

Decisions on appeals will be made by the Board of Trustees, or a duly designated Committee of Trustees, at the next regularly scheduled meeting of the Board of Trustees or Committee, following receipt of your written request for review. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached. The decision by the Board of Trustees or the Committee shall be final and binding on all parties.

Vision, Hearing, and Reimbursement Appeals to the Appeals Committee

You have 180 calendar days from the date of the notification letter to file an appeal of a Vision, Hearing or Reimbursement claim denial with the Appeals Committee. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review. Individuals who did not participate in the original decision will review your appeal.

Your appeal to the Appeals Committee must be made in writing. No verbal appeals will be accepted.

Decisions on appeals will be made by the Appeals Committee at the next regularly scheduled meeting of the Appeals Committee, following receipt of your written appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your appeal has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached. The decision by the Appeals Committee shall be final and binding on all parties except for any relief available through ERISA.

Short-Term Disability Appeals

You have 180 calendar days from the date of the notification letter to file an appeal of a short-term disability claim denial with the Appeals Committee. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review. Individuals who did not participate in the original decision will review your appeal.

Your appeal to the Appeals Committee must be made in writing. No verbal appeals will be accepted.

Decisions on appeals involving short-term disability claims will be reached within 45 days of your appeal. However, in special circumstances, up to an additional 45 days may be necessary to reach a final decision on a disability claim. You will be advised in writing within the 45 days after receipt of your appeal if an additional period of time will be necessary to reach a final decision on your disability claim.

Life Insurance Appeals

The deadline to file an appeal of a life insurance denial is within 180 days of the notice of denial of a life insurance claim. The written appeal must be filed with the Appeals Committee. A written notice regarding a determination of your appeal will be sent to you within 180 days from the date your written request for an appeal is received by the Appeals Committee.

Your appeal to the Appeals Committee must be made in writing. No verbal appeals will be accepted.

Dental Appeals

There is one mandatory first level appeal to ASO/SIDS and an optional second level appeal to the Appeals Committee.

Time Frames for Appeals Decision-making

After you submit a first level mandatory appeal to ASO/SIDS, ASO/SIDS will complete its review of your appeal and notify you of its decision within **60 days** of receipt of the appeal.

Your appeal to ASO/SIDS must be made in writing. No verbal appeals will be accepted.

If ASO/SIDS denies your appeal, you then have the option to appeal to the Appeals Committee. Your optional appeal must be filed within 60 days of the date of the decision of ASO/SIDS' appeal.

You are not required to file a voluntary appeal to the Appeals Committee in order to fulfill your appeal procedure obligations. Your decision whether to file such an appeal will not affect your rights to any other benefits under the Welfare Fund. The Committee's decision is final and binding on all parties except for any relief available through ERISA.

Your appeal to the Appeals Committee must be made in writing. No verbal appeals will be accepted. Once the appeal is received, the Appeals Committee will verify if ASO/SIDS has previously issued a denial. If you have not timely filed an appeal with ASO/SIDS, you will have forfeited your right to an optional appeal to the Appeals Committee.

In order to utilize the optional appeal to the Appeals Committee, your appeal must be received within **60 days** of the date of ASO/SIDS appeal decision. If the appeal is not submitted within that time frame, the Appeals Committee will not review it and ASO/SIDS's decision will stand**.** The Appeals Committee will complete its review of your appeal at its next regularly scheduled meeting following receipt of your written appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal.

Notice of Decision on Appeal

A written notice of the appeal determination will be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal; and
- If the denial was based on an internal rule, guideline, protocol or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request.

Limitations on When and Where a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until you have filed an appeal and a final decision has been reached on your appeal, or until the appropriate time frame described above has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

Lawsuits must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

In addition, any legal or equitable action related to any other claims you may have against the Fund, the Trustees, or any employee, fiduciary or representative of the Fund must be commenced within 365 days from the date that such claim arose and must be filed in the United States District Court for the Southern District of New York in New York County, New York. Such claims include, but are not limited to, claims related to COBRA, claims for penalties for an alleged failure to provide requested documents, claims to clarify your rights to future benefits under the Plan, and any other claim to which the statute of limitations set forth in ERISA Section 413 does not apply.

OTHER INFORMATION YOU SHOULD KNOW

Plan Amendments or Termination

The Board of Trustees intends to continue the Welfare Fund indefinitely, however, it reserves the exclusive right to terminate, amend, modify, reduce, suspend your benefits, or increase your cost of benefits under the Plan at any time. Upon termination of the Plan, the Trustees shall apply the monies of the Fund to provide benefits or to otherwise carry out the purposes of the Plan in an equitable manner, until the entire remainder of the Fund has been disbursed.

Representation

No Local Union officer, business agent, employee, employer or employer representative, Fund Office personnel, consultant or individual trustee or attorney is authorized to speak for the Trustees or commit the Board of Trustees on any matter relating to the Fund, without the express written authority of the Trustees.

The Board of Trustees is the named fiduciary that has the discretionary authority to control and manage the administration and operation of the Fund. The Board shall have the full, exclusive and discretionary authority to make rules, regulations, interpretations and computations, construe the terms of the Fund, and determine all issues relating to coverage and eligibility for benefits. The Board may also take other actions to administer the Fund as it may deem appropriate. The Board's decisions, interpretations and computations and other actions shall be final and binding on all persons.

Plan Interpretation

In carrying out their respective responsibilities under the Plan, the Board of Trustees and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan, and to decide any fact related to eligibility for and entitlement to Plan benefits. Any interpretation or determination under such discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary or capricious.

No Liability for the Practice of Medicine

Neither the Fund nor the Trustees nor any of their designees are engaged in the practice of medicine or dentistry; nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered by any health care Provider; nor shall any of them have any liability whatsoever for any loss or Injury caused by any health care Provider because of negligence, because of failure to provide care or treatment, or otherwise.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of Injuries or Illnesses you sustained, and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, Worker's Compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan may have the right to recover payments it makes on your behalf from a party responsible for compensating you for your Illnesses or Injuries, as permitted by applicable law. When a right to recovery exists, the following will apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, Illnesses and/or Injuries;
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights;
- If you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan;
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan;
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs; and
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery, in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, Illnesses and/or Injuries;

- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, as permitted by applicable law, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence;
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery, as permitted by applicable law. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan;
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  - The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan, or
  - You fail to cooperate;
- If you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan;
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, to the extent permitted by applicable law, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you; and
- The Plan is entitled to reimbursement from any Recovery, to the extent permitted by applicable law, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal Injury or Illness to you occurred and all information regarding the parties involved;
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. If you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan;
- You must not do anything to prejudice the Plan's rights;
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or Illness to you;
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf;
- The Board of Trustees has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary;

- If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of Injuries sustained by the covered person that Recovery shall be subject to this provision;
- The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies; and
- The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

Recovery of Overpayments

If a payment to you or your dependent or a Provider is determined to have been paid in error or otherwise be an overpayment, the Board of Trustees may commence legal action to recover the overpayment as well as interest and fees incurred in pursuing the recovery and/or offset future claim payments to recover the amount overpaid. **If the overpayment is not returned, the Fund may terminate your coverage and the coverage of your dependents until the overpayment is recovered.**

Stop Payments on Checks

If the Fund has issued you a payment, for example, for short-term disability or reimbursement on a claim, and you need to request that the Fund "stop payment" on such check and issue a new check, and provided that such check has not been cashed, your request for a "stop payment" must be made within six months of the date of issuance of the initial payment. If the request is not made within six months, or if the check has already been cashed, no re-payment will be issued.

Other Administrative and Funding Information

This section provides important information about third parties involved in providing and administering benefits.

Reimbursement Program benefits. Benefits are paid out of Fund assets. The Fund has contracted with ASO to provide claims and other administrative services.

ASO can be contacted at the following address:

Administrative Services Only ("ASO")
P.O. Box 9005
Lynbrook, NY 11563
Telephone: 800-537-1238

Dental Benefits. Benefits are paid out of Fund assets. The Fund has contracted with ASO/SIDS, to provide claims and other administrative services. The Fund pays ASO/SIDS a fee for these administrative services, plus the amounts required to pay Plan benefits.

ASO/SIDS can be contacted at the following address:

Administrative Services Only, Inc.
Self-Insured Dental Services ("ASO/SIDS")
P.O. Box 9005
Lynbrook, NY 11563
Telephone: 800-537-1238
Website: **http://www.asonet.com**

Vision and Hearing Benefits. Benefits are paid out of Fund assets. GHS/GHS and CPS provide access to Participating Providers and other administrative services. The Fund pays GVS and CPS a negotiated fee.

GVS/GHS can be reached at the following address:

General Vision Services/General Hearing Services
520 Eighth Avenue
Ninth Floor
New York, NY 10018
212-594-2580

CPS can be reached at the following address:

Comprehensive Professional Systems, Inc.
11 Hanover Square
Eighth Floor
New York, NY 10005
212-675-5745

Life insurance. Benefits are insured by Amalgamated Life Insurance Company ("Amalgamated"). The Fund pays premiums to Amalgamated for the coverage and Amalgamated assumes responsibility for the payment of benefits. Amalgamated can be contacted at:

Amalgamated Life Insurance Company
Attn: Policy Services
333 Westchester Avenue, N101
White Plains, NY 10604-2910
914-367-5000

Short-term disability benefits. Benefits are paid out of Fund assets and are administered by the Fund Office.

Scholarship and Recognition Programs. Benefits are paid out of Fund assets and are administered by the Fund Office and International Scholarship and Tuition Services ("ISTS").

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all participants are entitled to certain rights, as described below.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report ("Form 5500 Series") filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA").
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report ("Form 5500 Series") and updated SPD (subject to a reasonable charge for the copies).

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, Spouse or Dependent(s) if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependent(s) may have to pay for such coverage.

Prudent Actions By Fiduciaries

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

Enforce Your Rights

If your application for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, until you have followed and exhausted the Plan's claims and appeals procedures. Any lawsuit must be filed within 365 days from the notice of the denial of the appeal. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in the United States District Court for the Southern District of New York in New York County, New York. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have an application for benefits that is denied or ignored, in whole or in part, you may file suit subject to the limitations above in the United States District Court for the Southern District of New York in New York County, New York. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by calling 866-444-3272 or visiting EBSA's website at **www.dol.gov/ebsa.**

PLAN FACTS

OFFICIAL PLAN NAME	NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND
Employer Identification Number (EIN)	13-5615576
Plan Number	501
Plan Year	July 1 – June 30
Type of Plan	Welfare benefit plan providing hearing, vision, disability, dental, life insurance and certain reimbursement benefits.
Funding of Benefits	All contributions to the Welfare Fund are made by employers in accordance with collective bargaining agreements and participation agreements in effect with the District Council, the Fund, or related organizations. These agreements require contributions to the Welfare Fund at fixed rates. A copy of any such agreement may be requested or examined at the Fund Office.
Trust	Contributions to the Welfare Fund are held in a trust under The Agreement and Declaration of Trust Establishing the New York City District Council of Carpenters Welfare Fund, as the same may be amended from time to time. The custodian for the Trust is The Bank of New York.
Plan Administrator	The Welfare Fund is administered by a Board of Trustees composed of eleven trustees: five designated by employer associations and six designated by the District Council. Their names appear later in this SPD. The office of the Board of Trustees may be contacted at: **Board of Trustees** **New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014 212-366-7300
Plan Sponsor	The Welfare Fund is sponsored by the Board of Trustees. The office of the Board of Trustees may be contacted at: **Board of Trustees** **New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014 212-366-7300
Trustees	**Board of Trustees** **New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014 212-366-7300

Contributing Employers	The Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Welfare Fund on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and Unions participating in the Welfare Fund may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.
Agent for Service of Legal Process	**Executive Director** **New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014 Legal process may also be served on the Plan Administrator, the individual Trustees, any insurer of benefits, or, with regard to any such insurer, the supervisory official of the local state insurance department.

MEMBERS OF THE BOARD OF TRUSTEES

Trustees Designated by the District Council

	TITLE	ADDRESS
Joseph Geiger	Union Trustee, Co-Chair New York City District Council of Carpenters	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
Paul Capurso	Union Trustee New York City District Council of Carpenters	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
Michael Cavanaugh	Union Trustee New York City District Council of Carpenters	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
Graham McHugh	Union Trustee New York City District Council of Carpenters	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
Michael Rodin	Union Trustee New York City District Council of Carpenters	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
John Sheehy	Union Trustee New York City District Council of Carpenters	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014

Trustees Designated by Employer Associations

	TITLE/EMPLOYER ASSOCIATION	ADDRESS
David T. Meberg	Employer Trustee, Co-Chair Greater New York Floor Coverers Association	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
John DeLollis	Employer Trustee Association of Wall-Ceiling and Carpentry Industries of New York, Inc.	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
Kevin M. O'Callaghan	Employer Trustee The Hoist Trade Association	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
John O'Hare	Employer Trustee Building Contractors Association	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014
Michael Salgo	Employer Trustee The Cement League	**New York City District Council of Carpenters Welfare Fund** 395 Hudson Street New York, NY 10014

GLOSSARY

Active Employee	An individual who works for an employer that has an agreement with the Union that requires contributions to this Plan and who has met the Fund's eligibility requirements for Active plan participation.
Adverse Determination	A determination that reduces or denies benefits.
Beneficiary	The individual(s) or entity that you name to receive benefits under the Life Insurance coverage, upon your death.
Plan Administrator	The Board of Trustees.
Children	Your eligible Children, until the end of the month in which the Child reaches age 26, including your biological Child, adopted Child (including a Child who has been placed with you for adoption) or stepchild.
Deductible	The dollar amount you must pay each calendar year before the Plan pays benefits for covered services.
Disabled Child or Children	A Disabled Child is an unmarried Child of any age who is incapable of self-sustaining employment due to physical or mental handicap. The handicap must begin before age 26 when coverage for the Child would usually end and the Child must be covered under the Plan before coverage would otherwise end. A Child must be receiving Social Security Disability benefits to be considered incapable of self-sustaining employment.
Injury	A bodily Injury resulting directly from an accident and independently of other causes, which occurs while you are covered under this Plan.
In-Network Benefits	Benefits for Covered Services delivered by Network Providers and suppliers. Services provided must fall within the scope of their individual professional licenses. In general, In-Network Benefits have lower out-of-pocket costs for you than Out-of-Network Benefits.
Out-of-Network Benefits	Reimbursement for Covered Services provided by Out-of-Network Providers and suppliers. Out-of-Network benefits are subject to a Deductible and Coinsurance and generally have higher out-of-pocket costs.
Retiree	Retirees are participants who are no longer working for the City of New York and for whom the City of New York is making the required retiree contributions on your behalf.

NYC District Council of Carpenters Benefits Funds
395 Hudson Street
New York, NY 10014

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