

NEW JERSEY CARPENTERS HEALTH PLAN



**SUMMARY
PLAN
DESCRIPTION
EFFECTIVE
APRIL 1, 2011**



**NEW JERSEY CARPENTERS
HEALTH FUND
(Plan No. 501)**

OFFICE

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(EIN 22-6032181)**

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THIRD PARTY ADMINISTRATORS

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
MEDCO

FISCAL YEAR (PLAN YEAR) April 1 through March 31

This document constitutes the entire New Jersey Carpenters Health Plan and the Summary Plan Description of the New Jersey Carpenters Health Plan.

The New Jersey Carpenters Health Fund is a non-profit, self-administered, self-funded reimbursement fund governed by the Employee Retirement Income Security Act of 1974 (“ERISA”) and as such is not subject to State insurance laws.

Due to the fact this booklet is not printed annually, you may learn more about Plan amendments and healthcare updates from the NJ Carpenters Health Fund through the following methods:

NJ Carpenters Health Fund: 1-800-624-3096 or 732-417-3900

“Benefits Watch”

(Quarterly newsletter of the NJ Carpenters Funds)

Website: www.njcf.org

(Down-load printable version of updated Active Health Plan)

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the plan administrator: George R. Laufenberg, New Jersey Carpenters Funds, Raritan Plaza II, P.O. Box 7818, Edison, NJ 08818-7818. Phone (732) 417-3900.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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TO ALL ELIGIBLE EMPLOYEES:

The Board of Trustees of the New Jersey Carpenters Health Fund is providing you with this booklet explaining the benefits and the rules of eligibility of your group health plan.

The Hospital, Medical-Surgical, and Major Medical Benefits help you meet the cost of hospital and doctor services for most illnesses and injuries. The Prescription Drug Program provides coverage for most prescription items. This booklet replaces any booklets or certificates you may have received previously.

If you would like more information concerning the benefits available to you under the New Jersey Carpenters Health Fund, the Fund Office will be happy to assist you.

Sincerely yours,

THE TRUSTEES

BENEFIT COVERAGE SUMMARY LEVEL 1

For Eligible Active Employees:

DEATH	\$20,000.00
ACCIDENTAL DEATH (on or off the job)	\$20,000.00
ACCIDENTAL DISMEMBERMENT (Per schedule for accidents on or off the job)	

Loss of:

Both hands	}	\$10,000.00 (Paid to you)
Both feet		
Sight of both eyes		
One hand and one foot		
One hand and sight of one eye		
One foot and sight of one eye		

Loss of:

One hand	}	\$5,000.00 (Paid to you)
One foot		
Sight of one eye		

For Eligible Active Employees and Dependents:

Hospital Expense Benefits – Benefits are provided for you and each of your enrolled dependents in an acute or sub-acute care hospital.

Behavioral Health Benefits (Inpatient Mental Health/Substance Abuse) – There is a Managed Care Program in effect for behavioral health benefits. Please contact the Fund Office for assistance with finding a participating facility or provider to minimize your out-of-pocket expense.

Pre-Certification Program – All hospital admissions, emergency admissions, same-day surgeries and hospital transfers must be pre-certified. Failure to pre-certify may result in denial of claims.

Surgical & Medical In-Hospital Expense Benefits – Maximum payment as covered under our fee schedule. Participating providers accept our payment as payment-in-full.

THIS IS ONLY AN OVERVIEW OF YOUR
LEVEL 1 HEALTH BENEFITS.

For further information regarding specific benefits,
please refer to the appropriate section in this booklet.

BENEFIT COVERAGE SUMMARY LEVEL 2

For Eligible Active Employees and Dependents:

Same benefits as shown for Level 1 coverage, plus:

MAJOR MEDICAL EXPENSE BENEFITS – Payment for you and each eligible dependent subject to \$200.00 family deductible per benefit year under our fee schedule. The \$200.00 family deductible will be waived for treatment by participating providers.

\$10.00 co-pay for all office visits.

80% payment of our fee schedule for services rendered by non-participating providers.

Chiropractic Benefits – Family maximum of \$1,200.00 per benefit year payable at 80% of our fee schedule and subject to the family deductible. There is a participating chiropractic network with no deductible or co-pay.

Behavioral Health Benefits – Psychotherapy and medication management are payable at 80% of our fee schedule per eligible visit, per covered individual. There is a Managed Care Program in effect for this benefit. Contact the Fund Office for participating providers.

Pharmaceutical Prescription Benefits – Mandatory Generic Substitution Program. If you choose to obtain a brand name drug when a generic is available, you will pay the difference between the cost of the brand name drug and the cost of the generic drug, plus 20% of the balance remaining on the brand name drug.

- **Retail Pharmacy:**

Generic Drugs: \$5.00 co-payment

Brand Name Drugs: 20% co-payment when no generic available

- **Mail Order Drug Program: (90-day supply)**

Generic Drugs: \$10.00 co-payment

Brand Name Drugs: 20% co-payment when no generic available

**There is a Mandatory Mail Order Program
for maintenance medication.**

THIS IS ONLY AN OVERVIEW OF YOUR
LEVEL 2 HEALTH BENEFITS.

For further information regarding specific benefits,
please refer to the appropriate section in this booklet.

GENERAL INFORMATION

The New Jersey Carpenters Health Fund is administered by a Board of Trustees consisting of Employee-designated Trustees and Employer-designated Trustees. An Executive Finance Committee functions between meetings of the Board of Trustees. In addition, an Administrative Manager functions between meetings of the Committee and Board of Trustees.

The Board of Trustees reserves the right to amend or modify the Health Plan, in whole or in part, at any time, including retroactive amendments. The authority to make any such changes to the Health Plan rests with the Board of Trustees. Any such amendment or modification of the Plan shall be made by a resolution adopted by the Board of Trustees. To the full extent permitted by law, the Trustees shall have exclusive authority and discretion to interpret or construe any term or provision in the Plan, and to decide any matter relating to Plan administration, including, but not limited to, the following:

1. determining whether an individual is eligible for any benefits under the Plan;
2. determining the amount of benefits, if any, an individual is entitled to under the Plan;
3. interpreting all of the provisions of the Plan;
4. interpreting all the terms used in the Plan; and
5. determining questions of fact.

The Trustees' exercise of discretionary authority shall be binding upon any individual claiming benefits under the Plan, including but not limited to, the employee, eligible dependents, the employee's estate, and any service provider; and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious.

Until changed by the Trustees, the Fund may offer the benefits described herein through insurance or through self-administration. The benefits of this Fund are provided only to the extent assets are available in the judgment of the Trustees, considering all liabilities of the Fund, and the desire of the Trustees to maintain the benefits or provide other benefits. Although the Trustees hope to provide benefits indefinitely into the future, benefits (or a specific level or type of benefits) are subject to change and this Plan does not create a contractual right to continued receipt of benefits currently provided herein.

George R. Laufenberg, Administrative Manager, has been designated as the agent for service of legal process; service may also be made upon any Trustee.

The benefits are provided from the Health Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement. Such assets are used for benefits and administrative expenses. Payments are made to the Health Fund by the employers as required by the Collective Bargaining Agreements. A copy of the Agreement is available upon request to the Fund Office and is available for inspection in the Fund Office during normal business hours.

HOW YOU CAN DO YOUR PART

The benefits provided for you have been designed to pay a large part of your medical charges for a broad range of necessary services, treatments and supplies, and they will provide protection against the cost of serious illnesses and injuries.

Like any good tool, the Plan must be used properly if it is to endure. For the Plan to work successfully, it is important its costs be kept reasonable and, of course, the costs are governed by the claims submitted by you and your fellow workers.

When arranging for any service, discuss the charges with your doctor, the hospital, or others who are to furnish treatment. Also, discuss all other options of care and availability of in-network hospitals and facilities.

Satisfy yourself that the charges will not be more than you would pay if you were not covered by this Health Plan, nor more than is generally charged in your area for similar services. If you are in doubt as to the amount of any charges, consult the Fund Office. Remember, the amount of any charges which are in excess of the fee schedule are excluded under the Health Fund. Also make sure only necessary services are ordered. We encourage you and your eligible dependents to use our provider network whenever possible. Contact the Fund Office for participating providers. In this way, you will be doing your part in keeping the Health Fund available for everyone, and at the same time, you will be holding your own out-of-pocket expenses to a minimum.

REPORTING CRITICAL EVENTS

The Fund Office must be notified immediately if any of the following occur:

- **Change of address/telephone number**
- **Marriage or Divorce (must complete new beneficiary card)**
- **Addition or change in spouse's health coverage**
- **Addition or change in dependent children's health coverage**
- **Birth or adoption of a child**
- **Attainment of age 26 by dependent children**

- **Disability of employee or dependent**
- **Eligibility for Medicare/Medicaid of an employee or dependent**
- **Death of employee or dependent**
- **Change of beneficiary**
- **Eligibility for other health insurance**
- **Working in another jurisdiction**

A Notice of Change in Dependent Status Card must be completed and submitted to the Fund Office when any of the above events occur. In addition, proof of dependency in the form of a marriage certificate, divorce decree or birth certificate/proof of parentage document are also required. No coverage will be afforded to any dependents unless all proper documentation is received. Once the proper documentation is received your eligible dependents will be enrolled the first day of the following month. (Subject to applicable special enrollment rights described on Page 62).

Federal reporting regulations require that we submit the social security numbers of all participants of the New Jersey Carpenters Health Fund as well as those of their dependents who are covered by the Fund to the Centers for Medicare & Medicaid Services (CMS). As soon as you obtain a Social Security number for your child, please advise the Fund Office.

If you perform Carpenter's work in a jurisdiction not covered by our Collective Bargaining Agreement, contact the Fund Office immediately to obtain a reciprocal transfer form to insure prompt and proper transfer of your credits toward your eligibility.

WORKING SPOUSE POLICY

This policy requires working spouses to enroll in any health plan made available to them through their employment. If you wish to enroll your spouse in this Plan, you and your spouse must complete a verification form confirming that your spouse does not work or is an exempt spouse under the rules described below. Each year non-working spouses and exempt spouses are required to complete the verification form.

Highlights of the Working Spouse Policy:

- All spouses must complete the verification form from time to time at the Trustees discretion regardless of the spouse's employment status.
- A working spouse is required to enroll in any health plan made available to them through their employment unless the spouse is exempt. A spouse is exempt if they are self-employed, work part-time (i.e. less than 24 hours per week), their employer requires 100% self-payment (i.e. their employer does not contribute) or if there is no coverage available to the spouse through their employment.

- This policy only requires a spouse to be covered under their employer's health plan. (Even if there is a cost associated with the coverage, the spouse is required to enroll in coverage available through the spouse's employment, unless the cost is 100% self-payment).
- Carpenters Health Fund will provide secondary coverage for a spouse covered by their employer's plan.
- Carpenters Health Fund will provide primary coverage for a spouse who has no other coverage or is not working.
- A working spouse who is eligible for health coverage through their employer, but has missed the open enrollment election period, must enroll at the next available opportunity.
- Any spouse who does not comply by refusing to enroll, or those who fail to return the form, will have their coverage suspended until such form is returned.
- Policy applies to both Medical and Prescription Drug Coverage. A spouse is not required to enroll in a Dental or Vision program.

IMPORTANT INFORMATION YOU SHOULD KNOW

The healthcare benefits described in this booklet are available to you and your eligible dependents on the effective date of your coverage.

All employees and their eligible dependents and service providers have an obligation to supply the Fund Office with complete and accurate information reasonably necessary to determine whether to pay a claim. The Trustees reserve the right to suspend, discontinue or deny claims, benefits or payments to any service provider, employee or eligible dependent in the event that any of them makes a willfully false statement material to a benefits claim, furnishes fraudulent information or proof, or otherwise fails or refuses to provide information deemed reasonably necessary to determine whether to pay a claim. The Trustees shall have the right to recover, or to offset against future benefits, any payments made as a result of willfully false statements, fraudulent information or proof, a failure or refusal to provide information deemed reasonably necessary to determine whether to pay a claim, or mistake of fact by the Fund. The Trustees, at their discretion, may construe willfully false statements, fraudulent conduct, or failure or refusal to provide necessary information as gross misconduct for purposes of the Federal COBRA law which could preclude you from the ability to self-pay for continuation of benefits.

ASSIGNMENT OF BENEFITS

The Health Fund's liability with respect to claim reimbursement and release of information is to you, our member. When reimbursement is made to you, you have a legal obligation to pay all medical bills.

If you obtain services from an in-network provider, the provider will be paid directly. However, should you obtain services from an out-of-network provider, payment will be made directly to you as the plan participant. Assignment of benefits will not be honored for any out-of-network medical providers. It is your responsibility to pay the provider.

COORDINATION OF BENEFITS

All benefits for eligible expenses under this Plan will be excluded to the extent that such benefits are, or would be, available under any other group plan to which an employer contributes or makes payroll deductions for either, when the other plan does not include a coordination of benefits provision, or when the other plan does include a provision but is primarily liable.

Your spouse or any of your dependent children that are able to receive health benefits from their employer must do so. If they have the ability to receive health benefits from their employer, but elect not to, they will be ineligible to receive any benefits from the New Jersey Carpenters Health Fund. If your spouse or any of your dependent children have already elected not to receive health benefits from their employer, they must immediately reinstate this coverage at the first opportunity.

In determining whether this Plan or another Plan is primarily liable, the following shall apply:

- When a person is covered as an employee under one group contract, and as a dependent under another, then the employee's coverage pays first.
- Where a primary plan covers the patient under an HMO or other closed network, failure to obtain treatment within that network will result in a reduced payment by the New Jersey Carpenters Health Fund (up to a maximum of 50% of our fee schedule).
- When our member or his/her eligible dependents are covered under our plan, and our member is not working under the Collective Bargaining Agreement due to retirement or disability, and his/her spouse who is currently working is covered under another group health insurance, that plan is primarily liable.
- When our member or his/her eligible dependent is covered under Social Security Disability for two years, Medicare becomes the primary payer. (Subject to Medicare guidelines)

Order for Payment when More than One Group Insurance Covers a Dependent Child:

When a dependent child is covered under this Plan and another group health plan, the plan covering the parent whose birthday falls earlier in the calendar year pays first, unless the dependent child's parents are separated or divorced ("Birthday Rule"). In cases where the other group health plan utilizes the so-called "Gender Rule", the "Birthday Rule" will prevail for both plans due to its non-discriminatory nature.

If the dependent child's parents are separated or divorced, the following applies:

- The plan which covers a child of a parent who has financial responsibility for healthcare expenses of the child through a court decree will be the primary plan and pay benefits first.
- If a court decree is not specific:
 1. the plan of the parent with custody pays first;
 2. the plan of the spouse of the parent with custody (i.e. step-parent) pays second, and
 3. the plan of the parent without custody pays last.

The New Jersey Carpenters Health Plan will provide its regular benefits in full when it is the primarily liable plan. When this Plan is secondarily liable, it will provide a reduced amount, which when added to the benefits of the other group plan, will not exceed 100% of the charges for the patient's eligible expenses covered under at least one of the plans, but in no event will this Plan's liability as a secondary plan be greater than its liability as a primary plan.

Coordination of Benefits prevents duplication and works to the advantage of all members of the group. If an overpayment is made, you must make a prompt reimbursement to the Fund Office.

REPORTING OF INJURIES

The Fund Office must be notified of the following events:

- Motor Vehicle Accident
- Motorcycle/Recreational Vehicle Accident
- Lawsuits in process involving injury or illness
- Injury on the job
- Injury on property other than your own
- Injury resulting from product failure
- Participation in any research program or other arrangement which may require medical or psychiatric monitoring, treatment or procedures of any kind

SUBROGATION AND REIMBURSEMENT

Benefits are not payable if an injury or illness occurs through the act or omission of another party, or if any other insurance policy (including but not limited to worker's compensation insurance, motor vehicle insurance or homeowner's insurance) is obligated to cover medical expenses associated with a participant or beneficiary's injury or illness. Every employee, eligible dependent or service provider has an obligation to notify this Office of any events, including those listed above, which may indicate that a third party may be responsible for the illness or injury for which benefits may be claimed.

On occasion, you will be required to complete, sign and return an accident/injury letter explaining IN WRITING the "how" and "why" regarding a certain diagnosis or event noted on submitted bills. Should it be determined that another party is liable, the Fund may deny all related claims. If the appropriate carrier denies liability, IN WRITING, and you choose to pursue a lawsuit, we require you to contact the Fund Office to advise us of your case and provide us with your attorney's information. Benefits for such injury or illness may be temporarily advanced by the Fund provided that the benefit recipient signs an agreement to fully reimburse the Fund from any settlement, judgment, or other recovery against persons whose conduct may have caused the injuries. All benefits advanced on this basis must be reimbursed from any recovery regardless of how such recovery is characterized or apportioned. The participant, beneficiary, or dependent is responsible for paying any and all legal fees and expenses in connection with any recovery and the benefits advanced by the Fund shall not be reduced or offset by such legal fees or expenses or by any percentage or portion of such legal fees or expenses. Please be advised, any and all related bills (past, present and future) not currently in our possession will be paid out of your portion of the settlement.

By applying for or receiving benefits, the individual grants a lien to the Fund and agrees to reimburse the Fund for all such benefits received from the proceeds of any claim, settlement, judgment or other recovery from any third party, regardless of how the recovery is characterized or apportioned. Any reimbursement shall not exceed the lesser of the benefits paid or the amount actually recovered in any claim, settlement, judgment or other recovery from a third party.

The Fund may also require, as a precondition to payment of benefits, that the benefit recipient assign its right to recovery and sign other documents necessary to enable the Fund to recover any benefits advanced. No employee, eligible dependent or service provider shall do anything to prejudice the Fund's right to recover benefits advanced. A failure to execute and deliver documents required by the Fund shall not bar the Fund from placing a lien on any recovery or from enforcing its right to a lien, subrogation or reimbursement.

Persons covered under this Plan agree, upon accepting payment of benefits, to give a 10-day notice to the Fund Office of any steps to be taken to recover any monies from a third party (or their insurance carrier) including identifying the attorney retained for the purposes of seeking recovery and any appropriate carrier. If an action is commenced by the recipient of benefits, or his attorney, the recipient agrees to give notice of the action, to report periodically on the progress of the action and to give at least a 30-day notice prior to any pretrial conference. The Fund reserves the right to attend such pretrial conference and to otherwise intervene in the action if deemed necessary by the Fund; however, the Fund need not intervene in order to secure its right to a lien, an assignment, subrogation or reimbursement.

If any person covered by the Plan fails to execute and deliver all documents deemed necessary to effectuate the Fund's right to a lien, assignment, subrogation or reimbursement, or to give notice as herein required, or fails to reimburse the Fund as herein provided, the Fund reserves unto itself, in addition to all other remedies available to it by law, to withhold any other monies that might be due from the Fund, for either past or future claims, until such time as the Fund has recovered the full amount of its payments. The Fund shall not be liable for the payment of any legal expenses or attorney's fees incurred in connection with enforcing its rights under the Health Plan's subrogation rules and it reserves the right to increase the amount of its subrogation lien by the amount of such expenses and fees (or to otherwise require reimbursement of such expenses and fees).

OVERPAYMENTS

In the event the Fund Office makes a payment error, we will send you an overpayment letter requesting the money back. Failure to reimburse the Health Fund will result in the Fund Office withholding the amounts due from future health benefit claims.

AUTOMOBILE ACCIDENTS

Any injuries suffered in an automobile accident, or any injuries suffered involving an automobile, must be submitted to your automobile insurer who will serve as the primary payer of any claims incurred. Only a deductible of \$250.00 and the 20% co-payment of the first \$5,000.00 in total eligible charges will be considered for reimbursement through the New Jersey Carpenters Health Fund. Benefit payments are subject to the limits and guidelines of this Plan.

You CANNOT waive your Personal Injury Protection (PIP) to have the New Jersey Carpenters Health Fund be the primary payer for automobile related claims.

Automobile insurance coverage includes many items which most people are unaware of, such as but not limited to, shutting your vehicle doors on your fingers, injuries incurred while working on your vehicle, slips and falls while entering or exiting the vehicle, or removing items from your vehicle.

In the event your automobile insurance carrier terminates (or fails to authorize) medical coverage regarding a particular accident at a time when you still require treatment/therapy, please refer to the section titled SUBROGATION AND REIMBURSEMENT for information relating to the Plan's rules should you decide to pursue a lawsuit against the automobile insurance carrier or other entity.

MOTORCYCLE / RECREATIONAL VEHICLE ACCIDENTS

In regard to injuries suffered in either a motorcycle or recreational vehicle accident, only Level 1 benefits (excluding services provided by acute, sub-acute, or skilled nursing rehabilitation facilities) will be eligible for coverage under the New Jersey Carpenters Health Plan. No Major Medical /Co-Pay benefits will be eligible for reimbursement (i.e. follow-up office visits, physical therapy, occupational therapy, rehabilitation facilities, acute, sub-acute, skilled nursing, prescription drugs, or durable medical equipment). Recreational vehicles include but are not limited to ATV's, snow mobiles and any other motorized vehicles not ordinarily used primarily for travel upon public roadways.

When members or eligible dependents participate in **competitive events and/or exhibition events** with motorcycles, BMX bikes or other recreational vehicles, they **must** purchase any accident insurance that is available for the event. Otherwise, the NJ Carpenters Health Fund reserves the right to refuse to cover any injuries you may sustain. The Health Fund serves as secondary coverage, at Level 1 benefits only, with the exception of services provided by acute, sub-acute, or skilled nursing rehabilitation facilities for injuries in such competition.

MEDICAL NECESSITY

Your coverage helps pay healthcare expenses that are determined to be medically necessary. To be medically necessary, your tests, treatments, services and supplies must:

- be recognized by the American Medical Association (AMA) as appropriate and consistent with the symptoms, diagnosis and treatment of your illness or injury;
- be given to you as an inpatient only when the services cannot be safely provided as an outpatient or out of the hospital;
- not be provided solely for the convenience of your physician, hospital, other provider or you;
- not be experimental, investigational or educational in nature;
- not be for the purpose of research or other arrangement which may require medical or psychiatric monitoring, treatment or procedures of any kind.

The fact that a physician may prescribe, order, recommend or approve a service or supply does not, in itself, make it medically necessary for the treatment and diagnosis of an illness or injury or make it a covered medical expense. Determination of medical necessity by the Fund Office shall be final and binding on all members, dependents, and care providers.

ELIGIBILITY RULES & COVERAGE

In order to become eligible for the provisions of this Health Plan, an employee must be available for work under a Collective Bargaining Agreement which provides contributions to the New Jersey Carpenters Health Fund. In addition, you must be in good standing with your Local Union which means all applicable union dues have been paid.

Eligible Employee – An eligible employee is a person who is one of the following:

- (1) Employed under a Collective Bargaining Agreement which requires contributions to this Fund; or
- (2) A full-time employee of the New Jersey Carpenters Funds or an affiliated Fund; or
- (3) An employee of a Local Union, Regional Council, or one who renders service to said organizations; or
- (4) Other persons employed by employers affiliated with the Northeast Regional Council of Carpenters, under the Collective Bargaining Agreement, for whom the employer agrees with the Trustees to contribute to the Fund at a rate determined to be the cost of providing that particular level of benefits.

The provision for affiliated employers was discontinued in July 2006. Only affiliates that were allowed to continue in the Plan may remain in the Plan by continuing to pay at the determined rate for their employees who meet all eligibility requirements. Once there is a break in coverage by an affiliate, through the ceasing of payment for all of their eligible employees in the Plan after a 30 day period, there is no-re-entry into the Plan for an affiliate. The continuation provision of the Plan remains at the discretion of the Board of Trustees.

Owner Provision - Owners of corporate or LLC business entities, relatives of such owners, technical office staff (i.e. estimators, project managers) and company men/women agree to submit contributions to all Funds based upon an annual minimum of \$50,000.00 of gross wages earned per employee or 1,800 hours of service per shop employee. Eligible participants must be dues paying members in good standing. Any other individual seeking eligibility that is not described in this section must be approved by the Board of Trustees.

If any individual, described herein, works in the field, it is required that their benefits be paid based on their annual gross wages or annual hours or service with the aforementioned minimums being applicable. (The minimum required annual gross wages, and annual hours of service, are subject to change at the discretion of the Board of Trustees.)

Not included are any individuals who are proprietors, partners, or self-employed persons, (i.e. owners of non-corporate or non-LLC business entities) nor any employees who are (a) eligible or covered under any Carpenters Health/Welfare Fund other than the New Jersey Carpenters Health Fund (benefits are then coordinated, if applicable), or (b) represented by a Local Union or Regional Council affiliated with one of the Funds with which our Trustees have reciprocal agreements.

IMPORTANT FORMS

The following forms must be completed or supplied by the employee and mailed to the Fund Office prior to coverage beginning:

- **History Card**
- **Beneficiary Card**
- **Copy of Marriage Certificate**
- **Copy of Birth Certificates of spouse & eligible dependents**

Eligible Dependents – Eligible dependents are your eligible spouse and your children under age 26. Please refer to the section titled ‘Eligible Adult Children’ for enrollment requirements applicable to your children aged 19 to 25.

Eligible Spouse – Coverage for a new spouse becomes effective the first day of the month following the date of your marriage, provided a valid marriage certificate is submitted to the Fund Office within 30 days. Divorced spouses, including those who are divorced from bed and board and legally separated are covered until the effective date of your divorce decree or other applicable court order. It is the member’s responsibility to notify the Fund Office and provide us with a copy of the divorce decree or other applicable court order.

Eligible Adult Children (Ages 19-25)

Children are covered until the first day of the month following their 19th birthday. In order to continue coverage you must complete and return an Adult Child Verification Form for each child within 30 days of their 19th birthday.

The terms of the Federal Healthcare Reform Act mandated by the Patient Protection & Affordable Care Act (PPACA) requires eligible dependents to be covered up to their 26th birthday unless they are currently employed and receive, or have been offered, employer-based coverage.

It is your responsibility to contact the Fund Office immediately upon the change of eligibility status of your Adult Dependent Children at any time between the ages of 19-25. Failure to do so may result in your adult children being ineligible for health benefits or require reimbursement to the NJ Carpenters Health Fund.

Qualified Medical Child Support Orders – A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or State administrative agency that requires that medical coverage be provided under a plan for a child or children. A QMCSO usually results from a divorce, legal separation or paternity proceeding.

The Fund Office will notify you if a QMCSO is received with regard to your coverage. If you, your child, or the child's custodial parent or legal guardian would like a copy of the Plan's written procedures for handling QMCSOs, or if you have any questions about this process, please contact the Fund Office.

Michelle's Law – Effective January 1, 2010, a dependent child who is covered by this Plan as a full-time student shall continue as an eligible dependent notwithstanding a loss of full-time student status provided that:

- the loss of full-time student status results from a medically necessary leave of absence due to a serious injury or illness; and
- the Plan receives written certification from the child's physician that,
 - a. the child is suffering from a serious illness or injury; and
 - b. the leave of absence (or other change in enrollment) from the post-secondary school is medically necessary.

This special coverage is available for a maximum of one year. The one-year period begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

Initial Coverage – An eligible employee and his/her eligible dependents not currently covered by this Plan will become covered for one of the Levels of Benefits shown in the Benefit Coverage Summary on the first day of the calendar month following the date the employee accrues, during his/her first Qualification Year of participation in this Plan, the necessary contributions applicable to that Level of Benefits.

Maintaining Coverage – The eligibility for coverage after the initial year of participation is based upon contributions received for the periods worked from January 1st through December 31st of the previous Qualification Year, subject to your continued availability for work under a Collective Bargaining Agreement.

Required Contributions – The amount of contributions required for each level of benefits is subject to change by the Board of Trustees. Contact the Fund Office for the currently-effective amount of contributions required for each level of benefits.

Apprentices – An apprentice in good standing, and on whose behalf contributions have been remitted to the Fund, shall be covered at Level 1 after a 90-day probationary period has been satisfied and verification has been provided by a Council Representative or Administrative Manager of the Apprentice Fund. Coverage will begin the first day of the month following completion of the 90-day probationary period. Thereafter, earned credits will be doubled for the purpose of providing a higher level of coverage. The Doubling Provision only applies to the first 3 years of coverage in accordance with the established rules as determined by the Board of Trustees. The Doubling Provision is not applicable to or part of the Bank Credits Provision.

Determination of Continued Benefit Eligibility – During the first quarter of each year, the account of each employee will be reviewed for determination of benefit eligibility. Monies transferred by this Health Fund to another fund pursuant to reciprocity agreements shall not be the basis of Credits hereunder. If the employee has accrued the required credits and is in full compliance with all rules of the Fund, the employee will continue to be eligible for benefits. If the employee has not qualified for a Level of Benefits based on credits attained during the previous Qualification Year, the Bank Credits Provision may apply, provided the employee is available for work under the Collective Bargaining Agreement, has worked 250 hours or has earned \$2,000.00 in current health contributions and is in full compliance with the rules of the Health Plan.

Bank Credits Provision

The Bank Credits Provision allows the use of Bank Credits accrued during the prior Qualification Year to continue coverage during the current Qualification Year. Credits recorded in an employee's account in excess of the actual cost of coverage shall be deemed as Bank Credits, subject to change by the Board of Trustees. Bank Credits shall be used to afford the employee the maximum coverage.

In no case will a retired or disabled individual be permitted to use his banked credits and/or contributions toward continuation of coverage in the Active Employees Health Plan.

Clearing into a Non-Affiliated United Brotherhood of Carpenters Local Union – An employee who is clearing into a UBC Local Union whose members do not participate in this Plan will continue to have health benefits for a maximum of six months or until coverage is obtained under the new Collective Bargaining Agreement, whichever occurs first.

Benefits in Dispute – If the employer fails to remit benefit contributions on behalf of a member, the member may seek assistance from the Trustees of the Fund in order to secure the unpaid benefits. A letter must be sent to the Fund Office at the end of the year in which the delinquency has occurred requesting credit be applied to the member's account. However, in order to qualify for these Provisional Credits, the member must meet the following criteria:

- Provisional Credits can only be issued to accounts that have been referred to legal counsel for collection;
- Shop Steward Reports must have been submitted to, and received by, the Collection Department weekly. If a Shop Steward Report is received by the Fund Office after 30 days from the payroll weekend-ing, the member will not be eligible for legal credits;
- the member must submit copies of his/her corresponding pay stubs verifying his/her rate of pay, wages, and deductions by the employer;
- the member will only be eligible to receive credit for those shop steward reports that were received prior to the issuance of the contractor delinquent notice (C-34 letter);
- the member must cooperate with the Collection Department in its action against the non-paying employer; and
- Credit will not be given in the calendar year in which the work took place.

While you may not qualify for credits, it is the Fund's responsibility to pursue you and all delinquencies to the fullest extent.

SELF-PAYMENT PROVISION

Active Employees – Those actively working employees who attain a level of coverage through current year contributions may qualify for self-payment to a higher level of coverage. In order to qualify for self-payment to a higher level of coverage, an actively working employee must have been covered for the two previous years.

Such self-payment privilege is available only at the beginning of the benefit year (April 1). Payments shall be made by the employee in accordance with the guidelines set forth by the Board of Trustees.

Temporary Disability Provision (Illness credits) – A covered employee who is temporarily disabled due to sickness or injury and unable to perform any work, who was covered for benefits by this Fund for the last 48 consecutive months (4 years) prior to the current Qualification Year, and does not have the required eligibility credits, will receive credits for each regular working day (Monday through Friday) which was lost because of disability in accordance with the guidelines set forth by the Trustees. This credit shall be limited to a maximum of 60 days in one Qualification Year (which will provide you with Level 1 coverage), not to be issued in two consecutive years. These credits are not included under the Bank Credits Provision and Self-Payment Provision. Coverage obtained by Temporary Disability Credits will not be considered when determining eligibility under the Total Disability Provision. Credits shall be allowed only after the qualification year. The Trustees require proof of temporary disability. Proof submitted must consist of receipt of New Jersey Temporary Disability Benefits or Workers' Compensation Temporary Disability Benefits, and a statement from the attending physician regarding your return to work status. Proof must be acceptable to the Trustees, who may have the employee examined by a physician designated by the Trustees.

Total Disability Health Provision

A disabled individual qualifies for benefits and becomes an eligible disabled participant under the Disability Health Provision, with coverage through the NJ Carpenters Retired Health Plan, if all of the following conditions are satisfied:

1. **Social Security Award Letter** – The individual has received a Social Security Disability Award Letter;
2. **Active Coverage** – The individual has an “Active” level of coverage on the date the Social Security Disability Award Letter deems you disabled;
3. **15 Consecutive Years** – The individual has earned an “Active” level of coverage for benefits through the Health Fund for at least 15 consecutive years prior to the date of disablement;

4. **Pension** – The individual qualifies for, and is receiving, a Pension through the New Jersey Carpenters Pension Fund; and
5. **Union Dues** - The individual's union dues are paid up to date with his or her Local Union.

(Please contact the Fund Office for a copy of the Retired Health Plan to determine your eligibility for benefits from that Plan, or visit www.njcf.org for more information.)

Coverage obtained by (1) temporary disability credits, (2) bank credits, or (3) self-payment options, such as COBRA or otherwise, under the Active Employees Health Plan are not included as part of the period of years of coverage for purposes of determining eligibility under the Disability Health Provision. Contact the Fund Office for more details regarding the Retired Health Plan.

COVERAGE AFTER EMPLOYEE'S DEATH

If an employee dies while actively covered by this Plan, benefits for his eligible dependents will be continued to the end of the month following 9 months from the date of death. In no event will coverage for an employee's dependents be continued if the dependents do not meet the definition of eligible dependents.

If an employee is making a self-payment to obtain a level of coverage and the employee dies, his eligible dependents will be offered COBRA the first day of the month following the date of the death.

Your surviving dependents have the option to elect COBRA (see Continuation of Coverage After Death or Termination) at the expiration of the extended period allowed under the Plan's coverage.

TERMINATION OF BENEFITS

Subject to COBRA, coverage for the employee and the eligible dependents under this Plan will end on the earliest of the following date:

- April 1st of the current Qualification Year if the employee failed to earn enough contributions during the prior Qualification Year and is not otherwise eligible for continued coverage;
- The last day of the month in which the employee or dependent fail to satisfy any eligibility requirements set forth in this plan;

- The date on which an employee first ceases to work or be available for work under a Collective Bargaining Agreement that requires contributions to this Fund;
- The date on which a modification, amendment, or termination by the Trustees of this Plan results in a loss of eligibility for the employee or eligible dependents;
- The date of a divorce or legal separation. The participant must submit a copy of a divorce decree or other applicable court order to the Fund Office within 30 days of a legal and finalized divorce or legal separation.

Coverage for employees of the NJ Carpenters Funds, affiliated funds, Local Union, Regional Council or other persons employed by an Employer for whom the Employer agrees to contribute to the Fund at a rate determined by the Trustees to be the cost of providing a specified Level of Benefits, shall end on the last day of the month following termination of employment subject to continuation according to the COBRA Law.

CONTINUATION OF COVERAGE

COBRA – In compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), the New Jersey Carpenters Health Fund will offer continuation of group health coverage for members and their dependents, known as “qualified beneficiaries,” whose coverage would otherwise end as a result of a “qualifying event”. If you lose active coverage because you fail to earn sufficient contributions in a Qualification Year and/or you do not have sufficient Bank Credits to continue on an active level of coverage, then COBRA is the exclusive method by which you may continue your coverage in this Plan. In such a case, if you timely elect COBRA and are otherwise eligible, your current contributions and/or Bank Credits will be applied to reduce the applicable monthly premium for COBRA coverage. Once your current contributions and/or Bank Credits are exhausted, you will be responsible for timely payment of the applicable full monthly COBRA premium (a detailed discussion of COBRA premiums is set forth later in this Section).

Qualifying Event Notification – The Fund will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of covered employment or a reduction of hours in covered employment, death of the participant, or entitlement to Medicare, the participant’s employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events. In order to facilitate COBRA administration and to avoid delay or oversight, the Plan requests that you or your family also notify the Plan Administrator promptly and in writing of the occurrence of any of these events. The employee and the dependents have the responsibility to send notice to the Fund Office when any one or more of the following events occur:

- Death of a member
- Divorce or legal separation
- Child losing dependent status
- Eligibility for Medicare

Qualifying Events – Any of the following events qualifies for Continuation of Coverage if the event results in loss of coverage by a member or eligible dependent:

For Employees

- Insufficient hours of contributions
- Termination of employment (for reasons other than gross misconduct on your part)

For Spouses

- Death of a covered employee
- Insufficient hours of contributions or termination of your spouse's employment (for reasons other than gross misconduct)
- Divorce or legal separation from your spouse
- Your spouse becomes eligible for Medicare

For Dependent Children

- Death of a covered parent
- Insufficient hours of contributions or the termination of your parent's employment (for reasons other than gross misconduct)
- Divorce or legal separation of your parents
- The dependent no longer meets the definition of a "dependent child" as defined under the Health Plan
- The covered parent becomes eligible for Medicare/Medicaid

Notification by the employee and dependents must be made within 60 days of the later of the qualifying event or the date coverage would be lost. If you fail to notify the Fund Office, you will forfeit your rights for Continuation Coverage. Send notice to:

**New Jersey Carpenters Health Fund
Attn: COBRA
Raritan Plaza II
P.O. Box 7818
Edison, NJ 08818-7818**

When the Fund Office is notified of a qualifying event, you will be sent notification of your rights under COBRA and will be allowed to purchase the level of coverage in effect at the time of the qualifying event. Only health benefits are available. **The Continuation Coverage does not include disability, death, or dismemberment benefits.**

Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Members may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children. For each qualified beneficiary who elects COBRA Continuation Coverage, COBRA continuation coverage will begin on the date of the qualifying event.

The cost of the Continuation Coverage is on a self-pay basis, which means you must pay the cost each month to be covered for the next month. The specific costs will be provided to all eligible persons upon notice of the occurrence of a qualifying event. The amount will not exceed 102% of the cost for providing the benefits, (or, in the case of an extension of continuation coverage due to a disability, 150%).

If you elect Continuation Coverage, you must make your first payment for continuation coverage not later than 45 days after the date of your election (the date the Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

After you make your first payment for Continuation Coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for Continuation Coverage is due on the first day of the month. If you make a periodic payment on or before the first day of the month to which the payment applies, your coverage under the Plan will continue for that month without any break.

Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the month to make each periodic payment. Your Continuation Coverage will be provided for each month as long as payment for that coverage period is made before the end of the grace period for that payment.

If you do not choose the Continuation Coverage, your health benefits will end and you will not have another opportunity to elect this coverage. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to Continuation Coverage under the Plan.

Duration of Coverage – When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), the employee’s divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to 36 months.

When the qualifying event is the termination of covered employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for qualified beneficiaries, other than the employee, lasts until 36 months after the date of Medicare entitlement. For example, if an employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of covered employment or reduction of the employee’s hours of employment, COBRA Continuation Coverage lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

If the employee or anyone in the employee’s family covered under the Plan is determined by the Social Security Administration to be disabled and notice is given to the Plan Administrator within 60 days of the determination, the employee and the employee’s spouse and dependent children may be eligible to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. To be eligible for the extension, the Social Security Administration must determine that the disability started at some time on or before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of Continuation Coverage. You must make sure the Plan Administrator is notified of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA Continuation Coverage.

If the employee’s family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, the employee’s spouse and dependent children can obtain up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension is available to the spouse and dependent children receiving Continuation Coverage if the employee dies or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.**

However, the Continuation Coverage can end before the 18, 29 or 36 month limitation for any of the following reasons:

- After you elect Continuation Coverage you become covered under another group health plan that does not contain a pre-existing condition limitation as an employee, spouse or dependent;
- After you elect Continuation Coverage you become eligible for Medicare (under Part A, Part B, or both);
- The charge for the Continuation Coverage is not paid in full in a timely manner;
- The Fund no longer provides coverage.

In order to protect you and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Full-time employees of the New Jersey Carpenters Funds and affiliated funds should refer to their Employee Manual for information regarding eligibility rules and coverage.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

If you are on active military duty for 31 days or less, you will continue to receive healthcare coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 31 days, your coverage ends, but USERRA permits you to continue healthcare coverage for you and your dependents at your own expense for up to 18 months. This continuation right operates in the same way as COBRA coverage, described herein. In addition, your dependent(s) may be eligible for healthcare coverage under the Federal program known as TRICARE (which includes the old "CHAMPUS" program). This Plan coordinates its coverage with TRICARE.

If you receive an honorable discharge and return to work with a contributing employer, your full eligibility will be reinstated on the day you return to work as long as you return within one of the following time frames:

- 90 days of the date of discharge, if the period of service is more than 180 days;
- 14 days from the date of discharge, if the period of service was 31 days or more but less than 181 days; or
- one day after discharge (allowing 8 hours for travel) if the period of service was less than 31 days.

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

Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Plan within 30 days after you are re-employed following military service; it is also recommended that you notify the Fund Office, too.

Please note that, for a “leave of absence” covered by the Family and Medical Leave Act (“FMLA”), or for qualified military service, your employer must properly grant the leave and make the required notification and any required payment to the Fund. You should contact your employer to confirm that you are eligible for a “leave of absence.”

Contact your employer if you have questions regarding your eligibility for a “leave of absence.” Contact the Fund Office if you have any questions regarding Fund coverage during such a “leave of absence.”

DEATH OR ACCIDENTAL DEATH BENEFITS

The Death Benefit or Accidental Death Benefit is paid to the named beneficiary(s) in accordance with the beneficiary designation form on file in the Fund Office at the time of death of the covered employee. You must have an active level of coverage (Level 1 or higher) to receive this benefit. In the event there is no designated beneficiary(s), the benefit will be paid to the estate of the deceased.

An employee may change the beneficiary(s) at any time without the consent of the beneficiary(s). The most recent signed beneficiary designation form on file at the Fund Office shall determine the right to receive the Death Benefit. For additional information, contact the Fund Office.

ACCIDENTAL DISMEMBERMENT BENEFITS

The accidental dismemberment benefit is paid to you based on the applicable schedule of benefits set forth in the Summary of Benefits. Contact the Fund Office if you have had an accident on or off the job which results in a dismemberment. You must have an active level of coverage (Level 1 or higher) to receive this benefit.

YOUR HEALTH CARE BENEFITS

The various covered services or supplies you receive are called your “benefits”. Your benefits cover necessary medical expenses and provide protection for you and your family during times of illness or injury. You should read the following sections carefully to become familiar with what are eligible medical expenses, as well as the exclusions and limitations of your healthcare benefits. **If you have any questions regarding your health benefits, contact the Fund Office.**

LEVEL 1 BENEFITS – HOSPITAL / SURGICAL

PRE-CERTIFICATION PROGRAM

Pre-Certification is required for all hospital admissions, including maternity admissions, emergency admissions, same-day surgeries, sur-gicenters and hospital transfers.

Failure to pre-certify your hospital admissions may result in a denial of your claim.

Pre-certification must take place within 24 hours of the admission or the next business workday if you are admitted on the weekend or a holi-day. Whenever possible, call two weeks before a scheduled admission. Please note, there are two different telephone numbers on the back of your medical identification card. One number is for in-patient pre-certification (utilization management) and one number is for same-day surgery. Remember, it is your responsibility to make sure your medical provider contacts the appropriate number on the back of your medical identifica-tion card to pre-certify your admission.

A pre-certification number in itself is not an approval, nor does it authorize any surgery, treatment, procedure or admission. In addition, a pre-certification does not guarantee payment or coverage.

Our medical consultants may determine that another setting (i.e. hospital outpatient department, doctor’s office, surgical center), is medically appropriate for your condition and they may suggest other available alternatives.

If you decide to enter the hospital as an inpatient after receiving a denial, you may be liable for all or a portion of the eligible hos-pital charges.

If you believe the denial is unfair, you have the right to appeal to the Board of Trustees.

Out-of-Network Hospitals/Facilities – Participants in this Plan and their dependents are encouraged to seek medical treatment at an in-network hospital/facility with whom the Health Fund has entered into a Reimbursement Agreement. As to those participants and dependents that obtain treatment at an out-of-network hospital/facility, the liability of the New Jersey Carpenters Health Fund to pay said costs shall be limited to the amount that the Health Fund would have paid to an in-network hospital/facility. Any charges above our fee schedule will be the member's responsibility. Contact our Provider Relations Department for in-network hospitals/facilities, or the telephone number listed on the back of your medical identification card.

CASE MANAGEMENT PROGRAM/UTILIZATION

Case Management – This program assures quality medical care that is cost effective to you and the Fund. Individual case management may be provided for those members/dependents that have been identified as having an illness or injury that may require extensive medical care or guidance through the health care delivery system.

The case management program monitors the utilization of hospital admissions, discharge planning services, rehabilitation therapy, and other health care services that require pre-authorization.

Same-Day Surgery (SDS) Pre-certification – SDS procedures must go through the Fund Office for pre-certification. You must have your provider contact the Same-Day Surgery number on the back of your I.D. card for pre-certification. All pre-certifications must be obtained at least 72 hours prior to the scheduled procedure. Pre-certification is required for, but not limited to: manipulation under anesthesia, sleep studies, arthroscopic surgeries, tonsillectomy, biopsies, carpal tunnel, tubal ligation, hernia repairs, vasectomy, bunionectomy, excisions, cataracts, and pain management procedures. Remember, it is your responsibility to have your provider pre-certify SDS procedures through the Fund Office.

Discharge Planning – The Case Management Department oversees the coordination of post-inpatient care in conjunction with the facility's discharge planner. The facility's discharge planner may contact the Case Management Department in order to coordinate services that may be available through your benefits. Services that may be available through your benefits must be deemed medically necessary. All admissions to rehabilitation facilities must be pre-approved. Home services that are medically necessary include, but are not limited to, medical equipment, I.V. therapy, skilled nursing care, and physical therapy. Discharge planning helps to ensure a smooth transition to the appropriate level of care.

HOSPITAL BENEFITS

When you or an eligible dependent requires hospitalization, your physician makes the arrangements for admission to an acute or sub-acute hospital. Just show your Identification Cards to the admitting clerk at the hospital. **It is your responsibility to have your provider pre-certify all hospital admissions by contacting the number on the back of your medical identification card.**

Hospital Inpatient Care in Semi-Private Accommodations – If an injury or illness, including pregnancy related conditions for an employee or enrolled spouse, makes hospitalization medically necessary, bed and board, including special diets and general nursing care, are covered in an acute care hospital if they are consistent with the diagnosis and treatment of an illness or injury.

Hospital Inpatient Care in Private Accommodations – When you occupy a private room, you are covered up to the Plan limitations, for the same wide range of services as in semi-private accommodations. However, you will pay the difference between the hospital's charges for the private room and the hospital's average semi-private room and board rate.

Pre-Admission Testing (PAT) – Benefits are provided for diagnostic tests that are required prior to an inpatient hospital admission or same day surgery and are performed in the outpatient department of the hospital or your physician's office. Consult your physician regarding PAT.

Emergency Room Care – Benefits are provided for treatment of an accidental injury or for emergency medical care within 24 hours of the onset of a sudden and serious medical condition or medical emergency.

\$100.00 co-payment applies, waive if admitted.

To qualify as an emergency, the following four requirements must be met:

1. The symptoms must be severe.
2. The symptoms must occur suddenly. Cases in which symptoms have existed over a period of time, without the person seeking medical attention, will not be considered an emergency.
3. Immediate medical attention must be sought. If there is a significant time lapse between the onset of symptoms or an injury and the time that you seek medical treatment, the claim will not be considered an emergency.
4. Immediate care is medically necessary.

Benefits will not be paid under this part of the Plan if the hospital emergency room is used for non-emergent illnesses. If you continue to use the emergency room for the same condition without following up with a physician, repeated visits to the emergency room will not be considered emergent. Failure to follow up with your physician after an emergency room visit which leads to subsequent emergency room visits will be considered non-emergent.

If benefits are classified as non-emergent, claims will be eligible only under the Major Medical/Co-pay Benefits. Time of day that the care was rendered does not in and of itself constitute a medical emergency. The Fund Office has the right to request the emergency room report or any necessary documentation to determine proper classification of benefits.

Comprehensive Physical Rehabilitation Facility (Acute, Sub-Acute, Skilled Nursing Facility) – Services are available based on diagnosis and medical necessity. All admissions must be pre-approved.

SURGICENTER BENEFITS

As an alternative to hospital inpatient or outpatient surgery, you may elect to have your procedure performed at a surgicenter. You must contact the Fund Office to pre-certify your same day procedure at the surgicenter as well as to make sure the surgicenter is in-network to reduce your out-of-pocket expense. Non-participating surgicenters will be reimbursed only up to our fee schedule and you will be responsible for the difference.

BEHAVIORAL HEALTH BENEFITS (MENTAL HEALTH/SUBSTANCE ABUSE)

There is a Managed Care Program in effect for all behavioral health benefits. Please contact the Fund Office at (732) 417-0300 for assistance in finding a participating facility or provider to minimize your out-of-pocket expense.

Inpatient Admissions – All mental health and substance abuse cases are reviewed individually by the Managed Care Program. These services must be pre-approved by the Fund Office prior to the admission to any facility. The Case Manager will arrange for the necessary evaluation and placement with an appropriate contracted facility. All approved treatment at a participating facility will be covered in full. Payment for approved treatment at a non-contracted facility will be up to our fee schedule and the member will be responsible for any balance bills over and above our fee schedule. Contact the Behavioral Health Department at (732) 417-0300.

The above described coverage and pre-approval policy also applies to intermediate levels of treatment such as, but not limited to, partial hospitalization and intensive outpatient programs.

MEDICAL-SURGICAL BENEFITS

Reimbursement for eligible services is made based on 100% of our fee schedule. If services are rendered by a participating provider, the provider will accept our payment as payment in full for eligible services. If services are rendered by a non-participating provider, you will be responsible for the difference between 100% of our fee schedule and the provider's charge. Therefore, we encourage you to use participating providers whenever possible.

FEE SCHEDULE

In-Network – Participating providers are bound by their contract with Blue Cross Blue Shield.

Out-of-Network – Non-participating provider payments based on 100% or 80% of NJ Carpenters Health Fund Fee Schedule, depending upon benefit type.

***The NJ Carpenters Health Fund Fee Schedule is 120% of the current Medicare Resource Based Relative Value Scale (RBRVS).**

If you or the provider want to know what the Fund Office will pay for a particular service, a pre-determination for services must be submitted **IN WRITING** to the Fund Office by the provider. Fee schedules will not be given over the telephone.

Contact the Fund Office:

- To determine if your physician is a participating provider
- If you need the name of a participating provider or facility
- To determine eligible services under the Health Plan

Medical-Surgical Benefits are provided for you and your eligible dependents when you require the following services from a physician:

IN-HOSPITAL MEDICAL CARE

- Days Available - You are entitled to one physician visit per day to render medical (non-surgical) care.
- Concurrent Medical Care - Benefits are provided for concurrent medical care visits by other physicians to a hospital inpatient for multiple diagnoses when it is medically appropriate due to the nature or severity of the covered person's condition. However, the medical care must not be considered normal pre-operative or post-operative care.
- Consultations - You may receive benefits for one inpatient consultation by a specialist during each eligible inpatient hospital stay provided the consultation is requested by your attending physician in connection with a diagnosed condition. If your condition involves a number of different specialties, each specialist's initial consultation will be eligible for reimbursement.

SURGICAL CARE – Benefits are provided up to our fee schedule for operative or surgical cutting procedures, the reduction of fractures and dislocations, and for endoscopic and other surgical-diagnostic procedures wherever performed by your physician. Participating physicians accept our payment as payment in full.

If services are rendered by a non-participating provider you will be responsible for the difference between 100% of our fee schedule and the provider's charges.

SECOND SURGICAL OPINION – May be required for certain procedures at the discretion of the Fund Office.

ANESTHESIA – Benefits are provided up to our fee schedule when anesthesia is administered during a covered surgical, dental-surgical or maternity procedure and is billed for by an anesthesiologist (other than the operating surgeon or his assistant) who is not a hospital employee.

MANIPULATION UNDER ANESTHESIA (MUA) – Benefits are provided up to our fee schedule only for adhesive capsulitis of shoulder or arthrofibrosis of the knee when performed by an orthopedic surgeon only. MUA for any other reason is not a covered benefit.

ELECTRIC SHOCK WAVE THERAPY (ESWT) – Benefits for ESWT are eligible for plantar fasciitis and lateral epicondylitis only. This procedure must be pre-approved by the Fund Office and meet medically necessary criteria. Criterion includes documentation from your physician of a six month course of conservative treatment. ESWT is limited to a maximum of 2 treatments per lifetime not to be performed within 14 weeks of each other. In addition, only a high dose treatment protocol is eligible. Low dose treatments are ineligible. Eligible benefits are provided up to our fee schedule only.

ASSISTANT SURGEON – Benefits are also provided up to our fee schedule for the services of an assistant surgeon in a hospital when surgical assistance is medically necessary and not mandated by the facility.

MEDICAL CARE FOR ACCIDENTAL INJURY – Benefits are provided up to our fee schedule for initial emergency medical treatment of an accidental injury, provided the accidental injury is covered and there is not a third party payer who would be primarily liable (i.e. workers' compensation insurance, automobile insurance, homeowners insurance). Treatment must begin within 24 hours of the injury.

EMERGENCY MEDICAL CARE – Benefits are provided up to our fee schedule for initial emergency medical care rendered by a physician in the outpatient department of a hospital. See Emergency Room Care for what qualifies as an emergency.

AMBULANCE – Benefits are provided for professional ambulance services when being transported to a hospital only. The transfer must be based on medical necessity which is determined by our medical consultants. Patient or family transfer for convenience or non-medical necessity will be considered ineligible.

MATERNITY & NEWBORN CARE – Please contact our Nurse Case Managers at the Fund Office as soon as you know you are pregnant so they can monitor your care.

- Hospital and medical services for any condition related to pregnancy including childbirth, newborn care, abortion or miscarriage, are covered for enrolled female employees or for the enrolled spouse of any employee. **Obstetrical care is not available to dependent children.**
- The Fund Office considers newborn care to be all services provided within the first 30 days of the newborn's life, unless the newborn continues to be hospitalized exceeding 30 days.
- **High Risk Pregnancy** – Contact the Case Management Department at the Fund Office if you are considered a high-risk pregnancy. There are specialty high-risk Case Managers available to guide you through your pregnancy.
- **Birthing Center Benefits** – As an alternative to conventional hospital delivery room care, a person eligible for maternity benefits may elect to receive maternity care from an approved birthing center where services may be rendered by a licensed certified nurse-midwife. The nurse case managers must be contacted prior to the use of a birthing center.

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

DIAGNOSTIC X-RAY & LABORATORY EXAMINATIONS

- **Inpatient Hospital** – If you are admitted to a participating hospital as an inpatient and receive treatment for an injury or illness, benefits will be provided up to our fee schedule for diagnostic X-ray examinations and laboratory tests which are consistent with the diagnosis and treatment performed either by your physician or by hospital personnel, when ordered by your physician. During such diagnostic admissions, eligible physician services are also covered up to our fee schedule.
- **Out-of-Hospital Facility** – Eligible diagnostic X-ray and laboratory tests performed outside of a hospital are paid up to our fee schedule. Contact the Fund Office for participating providers.

Benefits are not available, however, for X-rays and laboratory tests in connection with care of teeth.

COSMETIC/PLASTIC SURGERY – Benefits are not available for any cosmetic purpose except for the correction of congenital anomalies or correction of conditions resulting from accidental injuries for which we are primarily liable for payments. Correction of traumatic scars will be reviewed on an individual basis.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

Under Federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, Federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

- **Reconstruction of the breast on which the mastectomy was performed,**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance, and**
- **Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.**

This coverage is subject to a plan's annual deductibles and co-insurance provisions. If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact the Carpenters Health Fund at 1-800-624-3096.

MASTECTOMY & PROSTHESIS

Mastectomy Bras – 2 per benefit year up to our fee schedule.

Breast Prosthesis – 2 foam per benefit year and 1 silicone every 3 years.

PHYSICAL THERAPY (Inpatient) – If you are eligible to receive medical care as a hospital inpatient and your condition also warrants physical therapy services, then benefits are provided up to our fee schedule. Benefits are not provided if your hospital admission is solely for physical therapy purposes.

PHYSICAL THERAPY (Outpatient) – All physical therapy, regardless of where services are rendered, will be eligible under Major Medical/Co-Pay Benefits and subject to the limits therein. Please refer to the Major Medical/Co-Pay Benefits. The Fund Office discourages the use of the hospital out-patient department for physical therapy. There are many free-standing physical therapy locations in our program that will accept our payment as payment-in-full. Contact the Fund Office for participating physical therapy providers.

PAIN MANAGEMENT PROCEDURES – All pain management procedures must go directly through the Fund Office for pre-certification. You must have your provider contact the Same-Day Surgery number on the back of your I.D. card for pre-certification. All pre-certifications must be obtained at least 72 hours prior to the scheduled procedure such as but not limited to epidurals (cervical and lumbar), transforaminals, SI joint injections, facet injections, nerve root blocks, medial branch blocks, and selective nerve root blocks. Epidural injections are limited to three within a 12-month period.

RADIATION THERAPY – Benefits are provided, up to our fee schedule, for therapeutic X-ray treatments (for a proven malignancy), radioactive isotope treatments and radium or radon therapy when services are rendered in the outpatient department of a hospital or outside a hospital. Contact the Fund Office for participating providers.

CHEMOTHERAPY – Benefits are provided, up to our fee schedule, for chemotherapy treatments administered in the outpatient department of a hospital, doctor's office or in your home. Contact the Fund Office for participating providers.

DIALYSIS – Benefits are provided, up to our fee schedule, for dialysis services on an inpatient basis, in the outpatient department of a hospital, free standing facility, or in the patient's home. Contact the Fund Office for participating providers. Physician charges will be reimbursed only if the physician is in attendance.

HOME DIALYSIS BENEFITS – Benefits will be provided, up to our fee schedule, for home dialysis when the home dialysis services are provided by and billed for by a hospital, free-standing dialysis center or home health agency. The facility or agency must make arrangements for training, equipment, rental and supplies on behalf of the patient. Payment will be made for these services on a per treatment basis. No benefits are payable for home nursing services in connection with the administration of dialysis. Contact the Fund Office for participating providers.

DENTAL CARE – Inpatient or outpatient hospitalization required for oral surgery or the treatment of any eligible dental condition must be pre-approved by the Fund Office.

Medical-Surgical and or Major Medical/Co-Pay Benefits (as appropriate) are provided for oral surgical services such as surgical treatment of malignancy of the mouth; treatment of jaw fractures and dislocations; removal of tumors of the mouth or jaw; accidental injury to the mouth; operative and cutting procedures for treatment of diseases and injuries of the jaw. These services are available when performed in the outpatient department of a hospital or in a physician's office. However, these services are covered for an inpatient stay only if the hospitalization is required because the patient has a serious medical condition that would make such services hazardous if rendered elsewhere.

Benefits are provided for the services of your dentist for the removal of impacted wisdom teeth when performed in the doctor's office. The impacted wisdom teeth must be verifiable by X-rays. If the removal requires hospitalization on an inpatient or outpatient basis, the admission must be pre-approved by the Fund Office.

No benefits are provided for other extractions or any dental services involving care of teeth, gingival tissue or alveolar processes.

ORGAN/BONE MARROW TRANSPLANTS

All transplants must be pre-approved by the Fund Office. Please contact the Fund Office immediately if you are a candidate for these services.

LEVEL 2 BENEFITS – MAJOR MEDICAL / PRESCRIPTIONS

Co-payment – \$10.00 co-payment for all office visits when using participating providers. Contact the Fund Office for participating providers or log onto: www.njcf.org.

Deductible – The first \$200.00 of the allowable expenses covered under your Major Medical/Co-Pay Benefit is your annual family deductible. The deductible is met when one covered person has satisfied the \$200.00 deductible, or two or more persons under the same family coverage have covered medical expenses totaling \$200.00 or more. The deductible amount is subject to change at the discretion of the Board of Trustees. When using participating providers, the deductible is waived and only certain co-pays apply.

After you have satisfied your family deductible, the Plan will pay 80% of the fee schedule of the eligible medical expenses for non-participating providers.

Eligible Medical Expenses – The expenses must be for services and supplies which are performed or prescribed by a physician and are medically necessary for the diagnosis or treatment of an illness or accident. The covered medical expenses allowed under this Plan are based on our fee schedule which is 120% of the current Medicare Resource Based Relative Value Scale (RBRVS).

The following services are Eligible Major Medical/Co-Pay Expenses:

- Physician office visits/consultations.
- One routine physical examination per benefit year, including required school physicals, gynecological examinations and pap smears.
- Well baby care.
- Immunizations provided by a licensed physician.
- Nutritional counseling limited to two visits for eligible bariatric surgery candidates.
- Diabetic teaching/nutritional counseling limited to two visits every two years for those with a diagnosis of diabetes.
- Orthopedic shoes, when medically necessary, one pair per benefit year payable at 80% of our fee schedule, no deductible.
- Ultra Violet Light Therapy limited to 3 visits per week.
- First pair of eyeglasses after cataract surgery is payable up to \$150.00 (deductible does not apply). Crystal lenses are excluded from coverage.
- Oxygen and its administration.
- Rental of a wheel chair, hospital bed, oxygen or other standard durable medical equipment (DME) required for therapeutic use, or purchase of such equipment if the cost would be less than the rental.

Durable Medical Equipment (DME) – If you need any durable medical equipment, you must contact the Fund Office. Our participating providers will deliver any medically necessary equipment to your home. All equipment must be FDA approved in the accepted class for that related diagnosis and submitted with a valid prescription. Replacement of eligible durable medical equipment is limited to once every five years with the exception of :

- Custom Orthotics – 1 pair every three years
- C-Pap Equipment – Replacement of mask and tubing every 6 months
- TENS Unit Supplies – Replacement leads
 - 2 lead – 1 pair per month
 - 4 lead – 2 pair per month
 - Both units- replacement wires once a year
- T.E.D. Stockings – Limited to compression greater than 30mm Hg. and less than 50mm Hg. along with valid prescription. (2 pair every 6 months)

PLEASE NOTE: It is your responsibility to call the Fund Office to make sure any DME equipment you are receiving is with a participating provider to avoid any out-of-pocket costs. All equipment received from non-participating providers will be subject to the deductible and reimbursed up to 80% of our fee schedule.

Items not primarily medical in nature will not be covered. Also, comfort and convenience items that can be used in the absence of an illness or injury by another family member are not covered.

Intravenous Therapy (I.V. Therapy) – If your physician recommends I.V. Therapy (including I.V. Therapy for the treatment of Lyme Disease), you must contact the Case Management Department for pre-authorization. Duration of I.V. Therapy for Lyme Disease will be approved in accordance with the CDC (Center for Disease Control) guidelines. We have agreements with participating providers to minimize your out-of-pocket expense.
No payment for I.V. medications and supplies ordered but not used.

Skilled Nursing Care – You must contact the Fund Office for pre-approval for skilled nursing care. Based upon medical necessity, the Fund Office will arrange to have a Registered Nurse or Licensed Practical Nurse (not a Home Health Aide) come to your home to render services. The physician's order does not guarantee reimbursement. New Jersey Carpenters Health Fund will not pay for custodial care, private-duty nursing, nor the services of a Home Health Aide.

Physical Therapy – Physical Therapy is a covered benefit for an acute illness or injury only. A valid prescription from your physician is required. If you use a participating provider, there is no deductible or co-payment. All services from non-participating providers will be subject to the deductible and reimbursed at 80% of **our fee schedule**. Services must be rendered by a licensed registered physical therapist. Limited to 24 sessions per acute illness or injury.

PHYSICAL THERAPY IS NOT ELIGIBLE WHEN USED FOR MAINTENANCE OF PAIN MANAGEMENT.

Occupational Therapy (OT) and Speech Therapy – OT and Speech Therapy are covered benefits for an acute illness or injury only. A valid prescription from your physician is required. All services from non-participating providers will be subject to the deductible and reimbursed at 80% of **our fee schedule**. Services must be rendered by a licensed occupational therapist or licensed speech pathologist. Limited to 24 sessions per acute illness or injury.

Hospice Care – Contact the Fund Office for available providers for this benefit.

Respite Care – \$500.00 per family per lifetime. Contact the Fund Office for information.

Accidental Dental – Benefits are provided for dental services resulting from an accidental injury for which we are primarily liable for payments.

Temporomandibular Joint Dysfunction (TMJ) – All claims related to TMJ treatment must be pre-authorized by the Fund Office. Please have the attending dentist submit the case history and the proposed fees along with the diagnostic X-rays to the Fund Office for review. Any additional phases of treatment must also be pre-approved. Any pre-approved services will be reimbursed to our fee schedule only.

Acupuncture Benefit – The acupuncture benefit is limited to \$1,000.00 per covered family per benefit year. Eligible charges are payable at 80% of our fee schedule after the Annual Family Deductible has been met. The maximum allowable charges are \$50.00 per treatment. All services must be provided by a licensed acupuncturist.

Chiropractic Benefit – The chiropractic benefit is limited to \$1,200.00 per covered family per benefit year. Eligible charges, including X-rays, are payable at 80% of our fee schedule after the Annual Family Deductible has been met. There is a participating chiropractic network. If you use a participating chiropractor, there is no deductible or co-pay. All services must be provided by a licensed Doctor of Chiropractics (D.C.). All eligible services that are approved will be counted toward the \$1,200.00 annual family maximum.

Manipulation Under Anesthesia (MUA) is not a covered benefit when performed by a chiropractor.

Early Intervention Program or School System Program – Early intervention programs, school system programs or similar programs that provide medical and related services may be available in your State. During a period when your child is (upon application would be or would have been) eligible to participate in such a program, this Plan will not provide coverage for otherwise eligible medical expenses to the extent that similar coverage is provided through such a program. If all or part of the services requested from the program are denied, all available levels of appeal must first be exhausted within the program. At that point, you may petition the Fund Office for determination of possible assistance. If coverage is approved, it is payable up to our fee schedule and subject to applicable limits in this Plan. If you are required to make a co-payment to the program, the Fund Office will cover the co-payment up to our fee schedule and subject to applicable limits in this Plan.

Behavioral Health – Charges for psychotherapy and medication management are payable at 80% of our fee schedule. To minimize your out-of-pocket-expense, contact the Fund Office or search the web-site at www.njcf.org for participating providers. Pre-approval is needed for all treatment with a participating provider. Psychotherapy is covered when provided by a licensed mental health professional including, but not limited to, licensed psychiatrist, psychologist, social worker, licensed professional counselor, and clinical nurse specialist supervised by a psychiatrist. Benefits are also provided, up to our fee schedule, for psychotherapy services received in the outpatient department of a hospital. Contact the Behavioral Health Department at (732) 417-0300.

Partial Hospitalization and Intensive Outpatient Programs for Mental Health and Substance Abuse Disorders – All cases are reviewed individually by the Managed Care Program. These services must be pre-approved by the Fund office prior to admission to the program. The Case Manager will arrange for the necessary evaluation and placement with an appropriate contracted facility. All approved treatment at a participating facility will be covered in full. Payment for approved treatment at a non-contracted facility will be up to our fee schedule and the member will be responsible for any balance bills over and above our fee schedule. Contact the Behavioral Health Department at 732-417-0300.

All psychological and neuropsychological testing must be pre-approved by the Fund Office. Testing for educational purposes is excluded. Coverage for approved testing will be allowed up to our fee schedule.

Any behavioral health services in connection with the commission of a crime, or services that are mandated by the court or any public agency, are not eligible.

Contact the Fund Office for participating providers if any of the following services or supplies are needed:

- Durable Medical Equipment
- I.V. Therapy
- Skilled Nursing Care
- Physical Therapy
- Rehabilitation Facilities
- Behavioral Health Benefits
- Oxygen
- Ambulance

MOTORCYCLE/RECREATIONAL VEHICLE ACCIDENTS

All Major Medical/Co-Pay services and supplies, including prescription drugs, made necessary by a motorcycle accident or any recreational vehicle accident, are excluded from your coverage. **Only Level 1 benefits (excluding services provided by acute, sub-acute, or skilled nursing rehabilitation facilities) are available when involved in a motorcycle/recreational vehicle accident, provided you are eligible for Level 1 benefits. Recreational vehicles include but are not limited to ATV's, snow mobiles and any other motorized vehicles not ordinarily used primarily for travel upon public roadways.**

PRESCRIPTION DRUG PROGRAMS

The prescription drug benefit is included as a part of your Major Medical/Co-Pay Benefit. Only legend drugs, drugs which by law require a prescription in order for the pharmacist to dispense, and drugs which are approved by the Food and Drug Administration for the diagnosis, are eligible under the prescription programs.

The following prescriptions are not covered:

- **Prescriptions drugs for the treatment of Infertility**
- **Non-Sedating Antihistamines (Allergy Drugs)**

Call the Fund Office for additional exclusions.

Prescription drugs can be filled at either a participating Retail Pharmacy or through the Medco Mail Order Pharmacy.

There is a **Mandatory Generic Substitution Program** for all covered drugs at both the Retail Pharmacy and mail order pharmacy. If you choose to obtain a brand name drug when a generic equivalent is available, you will pay the normal brand co-payment PLUS the difference between the cost of the brand name drug and the generic drug.

Retail Pharmacy – Present your card, along with your prescription, at any participating Retail Pharmacy. A co-payment is required at the time of purchase when using your prescription card. The pharmacist will inform you of your co-payment at the time your prescription is filled. Your co-payment will be as follows (subject to change by the Board of Trustees):

- **Brand Name Drugs:** 20% co-payment for a 30-day supply when there is no generic available.
- **Generic Drugs:** \$5.00 for up to a 30-day supply.
- **Specialty and/or Injectable Drugs:** 20% co-payment.

Mail Order Pharmacy – The Medco Mail Order Pharmacy provides you with the convenience of receiving maintenance medication right at your home. You can receive up to a 90-day supply of your maintenance medication. The current co-payments are as follows (Subject to change by the Board of Trustees):

- **Brand Name Drugs:** 20% co-payment for a 90-day supply when there is no generic available.
- **Generic Drugs:** \$10.00 for a 90-day supply.
- **Specialty and/or Injectable Drugs:** 20% co-payment.

The New Jersey Carpenters Funds has instituted a **Mandatory Mail Order Program for Maintenance Medications**. The program operates under the following guidelines:

- If you are taking any maintenance medication, you will be required to fill it through the Medco Mail Order Pharmacy.
- If you fill a maintenance medication at a Retail Pharmacy, you will pay the normal retail co-payment. However, after the third time you fill a maintenance medication at a Retail Pharmacy, you will be responsible for 100% of the cost of the prescription.
- Upon starting a new regimen of a maintenance medication, please initially fill the medication at a Retail Pharmacy for a 30-day supply, as your doctor may change the medication or dosage. This safeguards the member and the Fund from paying for a 90-day supply which may be changed to a different dosage or strength.
- To determine if a prescription you are taking is considered a maintenance medication, please consult www.medco.com or contact the Fund Office.

Medco Mail Order forms may be obtained at www.medco.com or by contacting the Fund Office at 1-800-624-3096.

Prilosec OTC Program (PPI Class of Drugs)

The New Jersey Carpenters Health Fund covers Prilosec OTC at 100% when filled at a participating Retail Pharmacy with a valid prescription from your doctor for a 90-day supply. Therefore, you will have no co-payment. Prilosec OTC is not available through the Mail Order Program. However, should you choose to elect any other brand name or generic PPI drugs, such as but not limited to, Nexium, Prevacid, Protonics, Aciphex, and Zegerid, you will be charged a 40% co-payment, with the exception of generic Omeprazole which is available to be filled at the standard generic co-payment.

Medco Claim Forms

If you fill a prescription at a participating retail pharmacy and you do not present your Medco card and pay for the prescription in full, you may submit a direct claim form to Medco. Reimbursement will be made up to our fee schedule, less the applicable co-payment. Medco prescription claim forms may be obtained at www.medco.com, by contacting Medco at 1-800-987-7838 or by contacting the Fund Office at 1-800-624-3096. Please note, if you did not comply with the Mandatory Mail Order Program for Maintenance Medications and you paid full price for your prescription at the retail pharmacy, you will not be reimbursed.

LIMITATIONS

All benefits except the Death or Accidental Death and Dismemberment Benefits are subject to the following limitations:

1. Any injuries suffered in an automobile accident must be submitted to your automobile insurer who will serve as the primary payer of any claims incurred. Only a deductible of \$250.00 and the 20% co-payment of the first \$5,000.00 in total eligible charges will be considered for reimbursement through the New Jersey Carpenters Health Fund. Benefit payments are subject to the limits and guidelines of this Plan.
2. In regards to injuries suffered in either a motorcycle or recreational vehicle accident, only Level 1 benefits (excluding services provided by acute, sub-acute, or skilled nursing rehabilitation facilities) will be eligible for coverage under the New Jersey Carpenters Health Plan. No Major Medical/Co-Pay benefits will be eligible for reimbursement (i.e. follow-up office visits, physical therapy, acute or sub-acute rehabilitation facilities, prescription drugs, durable medical equipment).
3. Costs for services obtained at a non-participating hospital will be limited to the amount the Health Fund would have paid to a hospital located in our participating network.

EXCLUSIONS

All benefits except the Death or Accidental Death and Dismemberment Benefits are subject to the following. You are NOT covered for:

1. Services eligible for payment under any other insurance. (i.e. Medicare, auto insurance, homeowners insurance or worker's compensation, etc.).
2. Services or supplies that are not considered medically necessary for your diagnosis and treatment.
3. The non-availability of other facilities will not be considered a valid reason for admitting a covered person to a higher level of care than is medically required for their condition.
4. Services you would not have a legal obligation to pay in the absence of this or any other insurance coverage.
5. Consultations required by hospital regulations which are not medically necessary for the disease entity or for stand-by services provided by hospital personnel.
6. Procedures, treatments, drugs, services or supplies that are not approved or are considered of a research nature by the Food and Drug Administration or the American Medical Association for the diagnosis.
7. Services or supplies that are received from a dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or any similar person or group.
8. Claims that are not submitted within one year (12 months) following the date of service. Appeals that are not submitted within one year (12 months) from the date the claim was processed.
9. Services to anyone who is on active military duty. "(Subject to applicable rights under USERRA.)"
10. Experimental, educational, investigational or ineffective procedures or treatments.
11. Services made necessary by a disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
12. Services rendered or supplies provided prior to the covered person's effective date, or after coverage is ended, for any reason unless specifically provided for in this booklet.
13. Charges which are in excess of our fee schedule.

14. Charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim or medical history form.
15. Personal services such as, but not limited to, haircuts, shampoos and sets, guest meals and radio/telephone/television/VCR/DVD/ tape rentals.
16. Durable medical equipment and personal convenience items which are primarily for comfort and convenience rather than a medical purpose, including but not limited to: air conditioners, humidifiers, purifiers, physical fitness equipment, heating pads, jacuzzis, whirlpools, tanning beds and similar supplies which are useful to a person in the absence of illness or injury.
17. Charges incurred during a covered person's temporary absence from the eligible provider's facility before discharge.
18. Services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable State laws or regulations.
19. Dietary or nutritional counseling for behavior modification classes or weight loss programs or food supplements (i.e. "Optifast", "Nutrisystem", "Weight Watchers", etc.).
20. Services for treatment of obesity unless the criteria for gastric bypass/lapband surgery is met.
21. Routine or periodic physical examinations, testing and immunizations which by law are required for employment. This includes immunizations required for traveling outside of the United States.
22. Charges for services or supplies which any school system or township is required to provide under any law or guidelines, or charges or supplies which any school system or township provides on a discretionary basis upon application or, other form or request by a participant or their dependent.
23. Any charges for services relating to learning disabilities, including psychological and neuropsychological testing.
24. Travel, whether or not recommended by a physician.
25. Surgery and any related services or supplies intended solely to improve appearance.
26. Repair of complications resulting from plastic or cosmetic surgery or from medications which were not medically necessary.

27. Treatment of sexual dysfunction, including but not limited, to erectile dysfunction and insertion of penile implants and pumps.
28. Treatment leading to or in connection with transsexual surgery, including prescription drugs.
29. Fertility treatments and associated prescription drugs including all surgical procedures and testing, including but not limited to, ovarian transplants, in vitro fertilization, zift, gift, and any assisted reproductive technology (ART).
30. Any claims pertaining to surrogate pregnancy, including delivery or any complications arising thereof.
31. Reversal of sterilization procedures under any circumstance.
32. Services and supplies for any condition related to the pregnancy of a dependent child.
33. Care in nursing home or home for the aged.
34. Custodial care such as sitters, homemaker's service, home health aide or care in a place that serves you primarily as a residence.
35. Services or supplies in connection with any procedure or examination not incident to or necessary for diagnosis of any injury or sickness for which bonafide provisional diagnosis has been made because of existing symptoms.
36. Services or supplies not listed as Eligible Medical Expenses.
37. Convalescent, custodial or sanitorium care or rest cures.
38. Exercise programs for treatment of any condition, including membership fees for fitness centers (i.e. Health Spas, YMCA, etc.).
39. Any claims incurred as a result of the commission of a crime (i.e. Driving While Intoxicated or Voluntary Illegal Drug Use, etc.) but not excluding claims incurred as a result of a crime of domestic violence.
40. Any claims incurred while in the custody of the State or local justice system.
41. Treatment for injuries sustained while engaged in unlawful conduct but not excluding injuries related to crime of domestic violence.
42. Any charges for services that are mandated by the courts, schools, or State, including but not limited to, marriage counseling, custody mediation, or mental health/substance abuse evaluation or treatment. Alcohol/drug rehabilitation to avoid or reduce jail time is not eligible.

43. Services provided during any part of a stay at a hospital, detoxification facility or residential facility chiefly for bed rest, rest cure, convalescent, custodial or sanitorium care or diet therapy.
44. Long term residential substance abuse or psychiatric admissions, or partial care or day treatment programs.
45. Services during a hospital stay or any period of a hospital stay which is primarily for diagnosis studies or examinations, unless the nature of the diagnostic procedure or the patient's physical condition is such that hospitalization is medically necessary.
46. All comprehensive treatment programs related to Pervasive Developmental Disorders, such as, applied behavioral analysis and similar treatments.
47. Auditory Processing evaluations are excluded in the absence of an acute illness or injury.
48. Your prescription drug co-payments are not reimbursable.
49. Vitamins and other medications available over-the-counter.
50. Biofeedback regardless of diagnosis.
51. Hypnotherapy regardless of diagnosis.
52. Services provided by an occupational therapist in the absence of an acute illness or injury.
53. Care and treatment for hair loss including wigs, hair transplants or any drug that promotes hair growth, with the exception of hair loss due to chemotherapy treatment.
54. Charges incurred when the patient is non-compliant with provider's plan of care.
55. Work hardening programs, including but not limited to, Functional Capacity Evaluations (F.C.E.).
56. Chiropractic care and physical therapy administered on the same day.
57. Prescriptions while at a residential facility, including nursing homes and assisted living facilities, in which your medications are not self-administered.
58. Treatment or care in a residential facility or halfway house for mental health or substance abuse.

59. Drug testing (urine or blood tests) except when included as part of a structured behavioral treatment program ie:, intensive outpatient program, partial hospitalization program.
60. Charges for hospital based pathologist billing for calibrating or maintaining hospital laboratory equipment.
61. Manipulation Under Anesthesia (MUA) is not a covered benefit unless specified.
62. Cognitive therapy in the absence of an acute illness or injury.
63. Autologous blood collection, processing and storage.
64. Non-FDA approved services, drugs, devices, treatments, products, including blood products, or therapies.
65. Infant formula is not a covered benefit. However, any infant formula requiring a prescription must be submitted to the Fund Office for review and determination of benefits.
66. Enteral nutritional feeding is covered only when through tube feeding and is the only source of nutrition.
67. Glucose Sensors associated with an insulin pump.
68. Private-duty nursing regardless of where services are rendered.
69. Vision therapy, including but not limited to, visual therapy, pleoptic training, vision training, optometric vision therapy, orthoptics, neuro-optometric rehabilitation, behavioral optometry, and developmental optometry.
70. Lasik eye surgery, regardless of diagnosis.
71. Routine vision services, including but not limited to, eye examinations, lenses, frames, and contact lenses.
72. Dental services involving care of teeth, except as specified under our medical benefits.
73. Orthodontic and periodontic services and treatments.
74. Hearing aid appliances, repairs to the hearing aid appliance or the purchase of batteries.

HOW TO SUBMIT CLAIMS TO THE FUND OFFICE

HOSPITAL SERVICES – Present your identification card to the hospital and they will file the hospital bill on your behalf.

MEDICAL-SURGICAL SERVICES – If services are rendered by a participating provider, present your identification card and the provider will file the claim on your behalf. Payment will be made directly to the provider for eligible services.

If services are rendered by a non-participating provider, you are responsible for paying the provider and filing the claim with the Fund Office. You will be reimbursed directly for eligible expenses upon receipt of your properly completed and substantiated “Health Insurance Claim Form”.

MAJOR MEDICAL/CO-PAY SERVICES – Benefit payments under your Major Medical/Co-Pay Plan will be made directly to you with the exception of the services or supplies that are rendered by our participating providers. Do not pay participating providers at the time services are rendered. The participating providers will submit the claim on your behalf, with the exception of appropriate co-payments. The \$200.00 family deductible will be waived for participating providers. You must submit a claim for all other Major Medical expenses. You will be reimbursed 80% of our fee schedule for eligible medical expenses upon receipt of your properly completed and substantiated “Health Insurance Claim Form”. Upon receipt of the E.O.B. “Explanation of Benefits”, you will be able to determine your co-payment, if any.

PLEASE MAKE ANY NEEDED COPIES FOR YOUR OWN RECORDS BEFORE YOU SUBMIT THE ORIGINAL STATEMENTS TO THIS OFFICE. ALL MATERIALS SUBMITTED WILL BE RETAINED FOR OUR FILES.

Contact the Fund Office to obtain the appropriate claim forms.

Send each completed Claim Form, together with all applicable itemized bills and receipts to New Jersey Carpenters Health Fund, Raritan Plaza II, P.O.Box 7818, Edison, New Jersey 08818-7818.

**ALL CLAIMS MUST BE SUBMITTED NO LATER THAN
12 MONTHS AFTER THE DATE OF SERVICE.**

APPEAL FOR TIMELY FILING

If a claim is not submitted to the Fund Office within the 12 month time limit, proof of timely filing, as well as proof of follow-up, must be submitted within 18 months from the date of service.

Proof of timely filing must consist of:

- copy of billing ledger
- identification of carrier/member
- addressee and address to which claim was submitted

CLAIMS APPEAL FROM PROVIDERS

Any appeal by a provider must be made within 12 months from the date the claim is processed.

For your protection:

1. Photocopies of claim forms are not acceptable.
2. Do not leave signed blank claim forms in the attending physician's office. Claim forms should be signed only after you have carefully reviewed the attending physician's services and fees.

Any person who knowingly files a statement of claim containing any false or misleading information or omits required information, is subject to criminal and civil penalties. Fraudulent claims may also cause immediate termination of coverage under the Health Plan.

Ineligible Claims – Once your claim has been processed, you will receive an Explanation of Benefits. If for any reason the claim you submit is not eligible or if we need additional information, you will be notified by the Fund Office. To request a review of the claim, you should follow the instructions described in the "Claims Denial and Appeals" section of this booklet.

Notice of New Jersey Carpenters Health Fund Privacy Practice

This notice describes how health information about you may be used and disclosed and how you may obtain access to this information.

The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information. The Fund acts in accordance with the Privacy Rule described in regulations issued by the United States Department of Health and Human Services, pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”).

The term “Personal Health Information” includes all individually identifiable health information transmitted or maintained by the Fund relating to your participation in the Fund, your physical or mental health, the provision of healthcare to you, or payment for the provision of healthcare to you, regardless of form (oral, written, electronic).

Uses and Disclosures of Health Information – Subject to certain limitations, upon your request, the Fund is required to give you access to your own personal health information.

Payment/Health Care Operations – The Fund has the right to use and give out your personal health information to pay for your healthcare and operate the Fund. For example, your personal health information may be used to pay or deny your claims, to collect premiums, to share your benefit payment with other insurer(s), or to prepare your “Explanation of Benefits” notices. In connection with payment and healthcare operations, we may disclose your personal health information to entities known as the Fund’s “business associates”, who include but are not limited to, the Fund’s various benefit managers, attorneys and accountants. The Fund has obtained agreements with its business associates in which the business associates have offered satisfactory assurances that they will appropriately safeguard your personal health information.

Law Enforcement – Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting. We may also disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public Health Reporting – Your health information may be disclosed to public health agencies as required by law (such as reporting disease outbreaks).

Other Uses and Disclosures Require Your Authorization – Disclosure of health information, or its use for any purpose other than those listed within, require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you must submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

The Fund may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Information about Treatments – Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights – You have certain rights under the Federal privacy standards, they include:

- the right to request restrictions on the use and disclosure of your protected health information.
- the right to receive confidential communications concerning your medical condition and treatment.
- the right to inspect and copy your protected health information.
- the right to amend or submit corrections to your protected health information.
- the right to receive an accounting of how and to whom your protected health information has been disclosed.
- the right to receive a printed copy of the Fund's notice of privacy practices.

Personal Representatives – You may exercise your rights through a personal representative. However, an individual purporting to act as your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be provided access to your personal health information or be allowed to take any action for you.

Notwithstanding the foregoing, the Fund retains the right not to treat a person as a personal representative in certain abuse, neglect or endangerment situations where the Fund concludes it is not in your best interest to do so. The Fund retains discretion to deny access to your personal health information to a personal representative to provide protection to those vulnerable individuals who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Minimum Necessary Standard – When using or disclosing personal health information, or when requesting personal health information from another covered entity, the Fund will make reasonable efforts to limit the use or disclosure of personal health information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a healthcare provider for treatment;
- uses or disclosures made to you or pursuant to an authorization initiated by you;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services; and
- uses or disclosures that are required by law.

New Jersey Carpenters Funds Duties – We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy practices that are outlined in this notice.

Right to Revise Privacy Practices – As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by change in Federal and State laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information – As permitted by Federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. Please send your request to our contact person listed at the end of this notice.

Complaints – If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern(s).

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern(s). Send all correspondence to our contact person listed at the end of this notice.

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person

The name and address of the person you can contact if you want more information about our privacy practices or if you have any questions, concerns or complaints is:

Rachel Corradi/HIPAA Compliance Officer
New Jersey Carpenters Health Fund
Raritan Plaza II
P.O. Box 7818
Edison, NJ 08818-7818
1-732-417-3900

This notice is effective on or after April 14, 2003

PLAN SPONSORS' USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Personal Health Information ("PHI"), as that term is defined in 45 CFR § 164.501, is disclosed to members of the Board of Trustees only to the extent such disclosure is necessary for the proper administration of the Fund and for processing appeals of denied claims. Such permitted and required uses or disclosures may not be inconsistent with HIPAA and regulations issued thereunder by the United States Department of Health and Human Services. The Fund will disclose PHI to the Board of Trustees only upon receipt of a certification by the Board of Trustees that this Summary Plan Description has been amended to incorporate the provisions set forth herein.

The Board of Trustees agrees to:

- a. Not use or further disclose such PHI other than as permitted or required by the Plan or as required by law;
- b. Ensure that any agents of the Trustees to whom they provide PHI received from the Fund must agree to the same restrictions and conditions that apply to the Trustees with respect to such information;
- c. Not use or disclose any PHI they receive from the Fund for any employment-related actions and decisions or in connection with any other benefit or employee benefit plan in which you participate;
- d. Report to the Fund any use or disclosure of the PHI that is inconsistent with the uses or disclosures described herein of which they become aware;
- e. Make available all PHI received from the Fund to the individual to whom such information pertains, in accordance with 45 C.F.R. §164.524;
- f. Make available all PHI received from the Fund for amendment and incorporate any amendments to such personal health information in accordance with 45 C.F.R. §164.526;
- g. Make available all PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
- h. Make their internal practices, books and records related to the use and disclosure of PHI received from the Fund available to the Secretary of Health and Human Services; and
- i. To the extent feasible, return or destroy all PHI received from the Fund and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The employees of the Health Fund shall have access to PHI maintained by the Fund. Fund employees' access to PHI maintained by the Fund is restricted to those plan administration functions, including treatment, payment and healthcare operation functions, performed by such individuals for the Fund.

Any employee of the Fund failing to comply with the privacy provisions of this Plan, with the terms of the Fund's Notice of Privacy Practices, or with the terms of the Fund's internal privacy guidelines and policies in accessing and/or using personal information maintained by the Fund, shall be subject to sanctions as described in the Fund's internal privacy guidelines and policies.

CERTIFICATES OF CREDITABLE COVERAGE

When your medical benefit coverage from the Fund ends, you and/or your dependents will be provided with a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you are covered under a health insurance policy, within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- on your request, within 24 months after your Fund coverage ends.
- when you are entitled to elect COBRA.
- when your coverage terminates, even if you are not entitled to COBRA.
- when your COBRA coverage ends.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Fund Office.

HIPAA SPECIAL ENROLLMENT RIGHTS

HIPAA requires the Fund to guarantee that participants and dependents, not otherwise enrolled for coverage from the Fund, must have special enrollment rights if certain events occur. These events include:

- A change in family status, such as marriage, divorce, birth, adoption, placement for adoption, or death. A new spouse becomes covered effective the first day of the month following the date of your marriage, as long as coverage is requested within 30 days of that date. A new dependent child becomes covered as of the date of birth or adoption, so long as coverage is requested within 30 days of that date.
- You previously stated in writing that you and or your dependents were waiving Fund coverage because of coverage under another medical plan, and that other coverage is lost for any of the following reasons:
 - termination of employment;
 - reduction in hours worked;
 - your spouse dies;
 - you and your spouse divorce or legally separate;
 - the other coverage was COBRA continuation coverage, and you or your dependent reaches the maximum length of time for COBRA continuation coverage; or
 - the other plan terminates because the employer, or other sponsor, did not pay the premium when due.

CLAIMS, DENIALS & APPEALS

Notice of Denial

If your claim for benefits is denied wholly or in part, the Plan Administrator shall notify you of such denial in writing. As described below, the deadline for such notice from the Plan Administrator will depend upon the type of claim being denied.

In the case of a claim involving urgent care, the Plan Administrator shall notify you of the Fund's determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Fund, unless you have failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable by the Fund. In the case of such a failure, the Plan Administrator shall notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Fund, of the specific information necessary to complete the claim. You shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator shall then provide you with notice of the denial of your claim, in whole or in part, as soon as possible, but in no case later than 48 hours after the earlier of (a) the Fund's receipt of the specified information, or (b) the end of the period afforded to you to provide the specified information.

In the case where the Fund has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Fund (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute a denial of benefits. The Plan Administrator shall notify you of such denial at a time sufficiently in advance of the reduction or termination on review to allow you to appeal and obtain a determination on review of the denial before the benefit is reduced or terminated. Any request by you to extend the course of treatment beyond the period of time or the number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Fund, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

In the case of a pre-service claim, the Plan Administrator shall notify you of the Fund's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Fund. This period

may be extended one time by the plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Fund, and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

In the case of a post-service claim, the Plan Administrator shall notify you of the Fund's denial of your claim within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Fund for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Fund, and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

In the case of a claim for Accidental Dismemberment benefits, the Plan Administrator shall notify you of the Fund's denial of your claim within a reasonable period of time, but not later than 45 days after receipt of the claim by the Fund. This period may be extended by the plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Fund and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that due to matters beyond the control of the Fund, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies you prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information.

In the case of a claim for Death or Accidental Death benefits the Plan Administrator shall notify you of the Fund's denial of your claim within a reasonable period of time, but not later than 90 days after receipt of the claim by the Fund, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Fund expects to render the benefit determination.

Any written notice of the denial of a claim for benefits shall: (a) set forth the specific reason or reasons for the denial; (b) refer to the specific Plan provisions on which the denial is based; (c) describe any additional material or information necessary for you to perfect the claim and explain why such material or information is necessary; and (d) describe the Fund's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following a denial on review. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, the notice shall include either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in reaching the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. Moreover, if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. If the denial concerns a claim involving urgent care, the notice will describe the expedited review process applicable to such claims.

Appeal of Denied Claims

You, or your authorized representative, may appeal and request the Trustees to reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied. This appeal must be put in writing and submitted to the Fund Office.

The following information must be given at the time of each written inquiry:

- (a) Name(s) and address(es) of patient and covered employee;
- (b) Covered employee's Identification Number/Social Security Number;
- (c) Date(s) of service;
- (d) Claim number, if any;
- (e) Name(s) of provider(s) of eligible services or supplies;
- (f) Reason(s) you think the claim should be reconsidered.

Exceptions to the foregoing requirement that appeals be submitted in writing shall be made only in the case of a claim involving urgent care. In such a case, an expedited review shall be undertaken in which the appeal of the denial may be submitted orally and all necessary information, including the Fund's determination on review, shall be transmitted between the Fund and you by telephone, facsimile, or other available similarly expeditious method.

If you have any additional information, documents, records or other evidence about the claim which was not given when the claim was first submitted, be sure to include it. Upon request, and free of charge, you will be provided with reasonable access to, and copies of, all documents, records or other information possessed by the Fund relevant to your claim for benefits.

A copy of pertinent material relative to your claim will be made available to the Trustees. In some cases, written authorizations to release certain information will be necessary and you will be informed accordingly.

Appeals should be submitted within 12 months of the date you were notified of the action taken to deny all or part of your claim. Upon receipt of the inquiry, your claim will be researched and reviewed thoroughly. Such review shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review of your claim on appeal shall not afford deference to the denial and shall be conducted by the Board of Trustees or a committee thereof. If the initial denial was based, in whole or in part, on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees, or committee thereof, shall consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such professional shall not be an individual who was consulted in connection with the initial denial, nor the subordinate of any such individual.

As described below, the deadline for the Fund to provide notice of the benefit determination on review will depend upon the type of claim being appealed.

In the case of a claim involving urgent care, the Plan Administrator shall notify you of the Fund's benefit determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of the denial by the Fund.

In the case of a pre-service claim, the Plan Administrator shall notify you of the Fund's benefit determination on review within a reasonable period of time appropriate to the medical circumstances and, in any event, within 30 days after receipt by the Fund of your request for review of a claim denial.

In the case of post-service claims, Death and Accidental Death benefits claims and Accidental Dismemberment benefits claims, the Fund shall make a benefit determination on review no later than the date of the meeting of the Board of Trustees, or committee thereof, that immediately follows the Fund's receipt of your request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, the benefit determination on review may be made by no later than the date of the second such meeting following the Fund's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination on review shall be rendered not later than the third meeting of the committee or board following the Fund's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify you in writing of the extension, describing the special circumstances and the date as of which the benefit determination on review will be made, prior to the commencement of the extension. The Plan Administrator shall then notify you of the benefit determination on review as soon as possible, but not later than 5 days after the benefit determination on review is made.

The Plan Administrator shall provide you with written notification of the Fund's benefit determination on review. In the event your appeal is denied, the written notice of the denial of the appeal shall: (a) set forth the specific reason or reasons for the denial; (b) refer to the specific Plan provisions on which the denial is based; (c) state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; (d) describe your right to bring a civil action under section 502(a) of ERISA.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, the notice shall include either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in reaching the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. Moreover, if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. In addition, the notice shall include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

The Plan is maintained pursuant to Collective Bargaining Agreements, and a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries at the Fund Office.

Upon written request to the Plan Administrator, participants and beneficiaries may receive:

- A complete list of the employer and employee organizations sponsoring the Plan, which list is available for examination by participants and beneficiaries; and
- Information as to whether a particular employer or employee organization is a sponsor of the Plan, and if it is, the sponsor's address.

YOUR RIGHTS UNDER ERISA

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

- (a) Examine, without charge, at the Fund Office and at other required locations such as union halls, all documents governing the Plan, including 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;
- (b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. There will be a minimum charge of \$25.00. If the number of pages exceeds 25 pages, there will be an additional charge of \$1.00 per page;
- (c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- (d) Continue healthcare coverage for yourself, your spouse and your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation rights.
- (e) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the 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 Administrator. If you have a claim for benefits which is denied, or ignored in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan’s decision, or lack thereof, regarding the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of the benefits of this Plan whenever in their judgment conditions so warrant, including making such action retroactive.

DEFINITIONS

Acute Care Hospital – An institution that receives compensation for providing the facilities for surgical and medical diagnosis and treatment of inpatients with a staff of physicians licensed to practice medicine and surgery. This institution provides supervised care that is furnished by registered graduate nurses 24 hours a day. Nursing homes, rest homes and institutions for the aged are not considered hospitals.

Balance Billing – The practice of physicians billing patients for the balance of charges not reimbursed by third-party payers.

Bank Credit Provision – Health & Welfare contributions accrued by a Fund participant exceeding the “actual cost of coverage,” for a given year, that may be applied towards health coverage in the following year in order to meet eligibility requirements and establish an active level of coverage. Bank Credit Provision is subject to change at the discretion of the Board of Trustees.

Benefit Year – April 1st thru March 31st.

Birthday Rule – For determining the order of primacy for dependent children. A plan covering the parent whose birthday falls earlier in the calendar year will be primary.

COBRA (Consolidated Omnibus Budget Reconciliation Act) – Enables qualified participants to continue group coverage through the Health Fund by their self-payments, subject to time limitations.

Contributing Employer – An employer who is required to make contributions to the Fund under a Collective Bargaining Agreement.

Co-Payment – Members financial responsibility under the guidelines of the Health Plan.

Credits – Monies paid to the Health Fund by contributing employers to a participant’s account based on the members hourly employment.

D.O.S. (Date of Service) – Date that actual services were performed.

Durable Medical Equipment (DME) – Equipment which services a specific therapeutic purpose in the treatment of an illness or injury that is medically appropriate.

Emergency – The sudden and unexpected onset of a condition requiring immediate medical treatment.

ERISA (Employee Retirement Income Security Act) – A Federal law that establishes uniform standards for employee-sponsored benefit plans.

Explanation of Benefits (E.O.B.) – A statement showing all the relevant information regarding a particular claim.

Fee Schedule – Amount of payment to be reimbursed for a service or procedure based on 120% of the current Medicare Resource Based Relative Value Scale (RBRVS).

Gender Rule – For determining the order of primacy for dependent children. A plan covering the male parent is primary.

HIPAA – (Health Insurance Portability and Accountability Act) – A Federal law that ensures health insurance portability, curtails fraud and abuse, and administrative simplification.

Inpatient – A patient registered for occupancy in a hospital.

Itemized Bill – Information that must be filed on a claim. Each claim must include the claimant's name, address and identification number, the provider's name, address, telephone number and provider identification number, name of the patient, date of service, CPT procedure codes, place of treatment, diagnosis code and charge for each service or supply.

Licensed Pharmacist – A person who is licensed by the State or other legal jurisdiction to prepare, preserve, compound and dispense drugs.

Local Union and Regional Council – One of the groups of the United Brotherhood of Carpenters and Joiners of America as listed in the back of the booklet.

Case Management/Utilization – A program that assures quality medical care that is cost effective both for the Health Fund and the member.

Medical Record – Complete individual folder of personal and confidential health information kept by physicians and hospitals.

Non-Participating Provider – A provider who does not have an agreement with the Fund to accept a specific fee schedule.

Other Providers – Other licensed practitioners that the Fund Office recognizes are licensed psychologists and other licensed healthcare professionals who deliver healthcare services.

Outpatient – A person obtaining services at a hospital when admission for bed occupancy is not involved.

Participating Provider – A provider/facility who has a signed agreement to accept a specific fee schedule.

Physician – A doctor or surgeon who is licensed to practice medicine. The term physician includes Doctors of Medicine, Osteopaths, Podiatrists, Chiropractors and Doctors of Dental Surgery.

Pre-Certification – The notification to the Fund Office of any inpatient hospital admissions, same day surgeries or hospital transfers. Failure to notify the Fund Office will result in a penalty.

Pre-Determination – A written submission of the proposed treatment plan from the provider of service to include the fees to be charged, diagnosis, procedure codes and supportive documentation. The response from the Fund Office does not constitute a promise of payment.

Qualification Year – The calendar year ending each December 31st from which contributions determine coverage the following April 1st.

Sub-acute Care – Services to patients who do not require the intensive level of treatment provided by the acute care setting of a hospital, but whose complex medical conditions require medical supervision, intensive nursing care, and other specialized equipment and rehabilitation services in a protective healthcare setting.

Surgicenter – A freestanding surgical center which provides ambulatory, same-day surgery services to covered persons.

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**AFFILIATED GROUPS
EMPLOYEE GROUPS**

NORTHEAST REGIONAL COUNCIL OF CARPENTERS

LOCAL UNION #255
(Formerly – LU 121, 393, 542, 623, 1489, 1743, 2018 & 2250)

LOCAL UNION #254
(Formerly – LU 31, 155, 455, 620, 781, & 1006)

LOCAL UNION #253
(Formerly – LU 6, 15, 124 & 1342)

LOCAL UNION #252
Mill Cabinet
(Formerly – LU 821 & 2098)

LOCAL UNION #251
Floorlayers
(Formerly – LU 29 & 2212)

LOCAL UNION #715
Millwrights

LOCAL UNION #39
Tapers

**AFFILIATED GROUPS
EMPLOYERS GROUPS**

Building Contractors Association of New Jersey
Associated General Contractors of New Jersey
Drywall and Interior Systems Contractors Association, Inc. of New Jersey

RECIPROCAL AGREEMENTS

The New Jersey Carpenters Health Fund is signatory to the International Master Reciprocal Agreement for Health & Welfare Funds.

MERGER DATES

L.U. 2212 - January 1, 1998
L.U. 15 - January 1, 1999
L.U. 31 - January 1, 1999
L.U. 1342 - January 1, 1999
L.U. 6 - April 1, 2002
L.U. 821 - January 1, 2006

TERMINATION OF THE FUND

In the event that the Fund is terminated, the Trustees shall apply the assets of the Fund to pay obligations then due and any expenses associated with termination of the Fund. Any balance thereafter remaining shall be applied in such a manner as will, in the judgment of the Trustees, effectuate the purposes of the Trust under which the Plan is maintained. In no case shall any Fund assets revert to any Employer, to any association of Employers, the Union, or to the Employees, their spouses and dependents. Upon disbursement of all the assets of the Fund, the Plan and Fund will terminate.

– NOTES –

– NOTES –

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