NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS BENEFIT FUNDS

NYC District Council of Carpenters Welfare Fund

summary plan description

for employees and retirees of the city of new york

inside front cover

4502.11
NYCDCC Welfare City SPD
Layout #1 8/7/03
Marjorie Gross & Company

TABLE OF CONTENTS

4502.11
NYCDCC Welfare City SPD
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Layout #1 8/7/03
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ABOUT THIS BOOKLET

This handbook summarizes the benefits provided under the New York City District Council of Carpenters Welfare Fund (the "Fund") as of April 1, 2003, and it replaces all earlier descriptions you may have received. It is intended to provide an easy-to-understand explanation of your benefits. It does not include all provisions in the official governing documents and insurance contracts, especially those relating to situations that don't occur often or that affect only a few participants. In the event of any conflict between this summary and the official plan documents, the official plan documents always govern.

From time to time there may be changes in the benefits and/or procedures under one or more of the plans that make up the Fund. In such a case either the administrator of the affected plan or the Fund Office will notify you in writing of any change. Announcements will be sent directly to you at the address that appears in Fund Office records. For this reason, it is important to remember to notify the Fund Office if your address changes. You should also keep announcements of changes with this booklet.

This booklet summarizes only the benefits you receive under The New York City District Council of Carpenters Welfare Fund. It does not describe any other employment-related benefits you receive.

Ayuda en Español

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

AN OVERVIEW OF YOUR WELFARE BENEFITS

The benefits you receive under the New York City District Council of Carpenters Welfare Fund (the "Fund") include:

- a prescription drug benefit;
- dental benefits;
- a vision benefit;
- a hearing aid benefit;
- a short-term disability benefit;
- a life insurance benefit; and
- a scholarship program that can provide financial assistance for your children's education.

This handbook offers a comprehensive resource you can use when you or your family members need information about any of your benefits. It's been organized in a way that we hope will give you quick access to easy-to-understand explanations of your benefits.

To make the best use of your benefits, you are urged to review these materials carefully and share them with your family. We hope this information will answer all of your questions. However, if you need more information, please contact:

About your…	Call…
Dental coverage	Self-Insured Dental Services 877-592-1683 516-396-5500 718-204-7172
Prescription drug program	Caremark 800-378-0972 800-831-4440
Vision and hearing aid participating providers	Comprehensive Professional Systems Inc. 212-675-5745 General Vision Services 212-594-2580 Vision Screening (vision only) 800-652-0063
Life insurance and disability benefits	The Fund Office 212-366-7300 800-529-3863
Scholarship program	The Fund Office 212-366-7300 800-529-3863
Plan administration and all other questions	The Fund Office 212-366-7300 800-529-3863

Participants may also seek assistance or information from the U.S. Department of Labor regarding their rights under the federal laws known as "ERISA" and "HIPAA."

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ABOUT YOUR PARTICIPATION

This section describes the eligibility rules for prescription drug, dental, vision care, hearing aid and life insurance coverage that apply to eligible Active Employees, Retirees and covered dependents. The different rules that apply for disability and scholarship benefits are explained in the sections on those benefits.

Eligibility for Active Employees

You are eligible for coverage if your work is covered by a collective bargaining agreement under which the City of New York (the "City") agrees to make contributions to the Fund on your behalf.

When we use the term "Covered Employment" in this booklet we mean periods of employment when the City contributes to the Fund on your behalf.

Eligibility for Retirees

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

Dependent Coverage

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

- lawful spouse or registered domestic partner;
- unmarried Children, until December 31 of the year in which they reach age 19;
- unmarried Children, until they reach age 25, if they are full-time students at an accredited educational institution;
- unmarried Disabled Children of any age who are primarily dependent upon you for support; and
- dependent parents (if you are not married and have no eligible dependent Children, you may cover a parent[s] who lives in the United States and is claimed as a dependent on your federal income tax return for the preceding year).

In the section called "Glossary" you'll find the definitions of "Children," "Disabled Children," and other important plan terms.

Coverage for the dependent Children described above generally continues until the end of the year in which they reach the limiting age or graduate. If a dependent child marries, his or her coverage ends immediately.

Coverage for your eligible dependents starts at the same time as your coverage, provided you complete the required enrollment materials (described below), and they will receive the same dental, prescription drug, vision care and hearing aid coverage that you do. There is no life insurance for covered dependents.

To make sure coverage for your dependents starts at the same time as your coverage, you need to provide enrollment documents to the Fund Office. You must provide, as applicable:

- a copy of a marriage certificate if you are enrolling a spouse;
- a copy of a certificate of domestic partner registration if you are enrolling a domestic partner;
- a copy of a birth certificate or documentation of adoption if you are enrolling a child;
- a copy of your tax return from the previous year if you are enrolling a dependent parent; or
- any other materials that the Fund Office may require to verify a dependent's eligibility.

If you acquire dependents after your coverage begins, they would become covered on the date they become eligible dependents.

To cover an eligible dependent, you must provide proof of dependent status, as specified by the Fund Office.

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is an order issued by a state court or agency that requires an employee to provide coverage under group health plans to a child. A QMCSO usually results from a divorce or legal separation. Whenever such an order is received by the Fund, its qualified status is carefully reviewed by the Fund in accordance with QMCSO procedures adopted by the Trustees and federal law. For more information on QMCSOs, or to obtain a copy of the Fund's QMCSO procedures free of charge, contact the Fund Office.

Changes in Status

After your coverage under the Fund begins, it is important that you **notify the Fund Office immediately by calling toll-free 800-529-3863** if you have either a change of address or one of the changes in status described below, including:

- marriage, divorce or annulment;
- termination of a domestic partnership;
- birth, adoption of a child, or placement of a child with you for adoption;
- a dependent child reaches a limiting age or otherwise ceases to be eligible for dependent coverage (for example, due to marriage or end of full-time studies);
- you take a leave of absence, including military leave and leave for family or medical purposes;
- a covered dependent dies; or
- your employment status changes, i.e., termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, or if the eligibility conditions of another employee benefit plan you or your dependents participate in change and, as a result, that individual becomes (or ceases to be) eligible under another plan.

If you have coverage when a child is born, your newborn will automatically be covered under your medical coverage for illness or Injury for 30 days from the date of birth. To continue coverage for your child beyond that time, you need to enroll the child, so be sure to call the Fund Office at 800-529-3863.

The Fund complies with the special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Continued Coverage During Certain Leaves of Absence

Family and Medical Leave. Under the Family and Medical Leave Act (FMLA), you may continue to be covered by the Fund while on a leave of absence for specified family or medical purposes, such as the birth or adoption of a child; to provide care for a spouse, child or parent who is ill; or for your own serious illness. If you are eligible for FMLA leave for one of the above qualifying family and medical reasons, you may receive up to 12 weeks of unpaid leave during a 12-month period. During this leave, you may be entitled to receive continued health coverage under the Fund under the same terms and conditions as if you had continued to work. Your employer is required to continue to pay your contributions for that coverage during the period of leave. To be eligible for continued benefit coverage during your FMLA leave, your employer must notify the Fund that you have been approved for FMLA leave. Your employer, not the Fund, has the sole responsibility for determining whether you are granted leave under FMLA. If you do not return to Covered Employment after your coverage ends, you are entitled to COBRA continuation coverage, as described later in this section. (If you do not return to covered employment at the end of your leave you may also be required to provide reimbursement for the cost of coverage during your absence.)

Continued coverage during military leave. If you are on active military duty for 31 days or less, you will continue to receive health care 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, USERRA permits you to elect COBRA continuation coverage for you and your dependents at your own expense for up to 18 months. (See later in this section for more information on COBRA.)

When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating employer, provided that you return to employment within one of the following time frames:

- 90 days of the date of discharge if the period of military service is more than 180 days;
- 14 days from the date of discharge if the period of military service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an Injury resulting from active duty, these time limits may be extended for up to two years. Contact the Fund Office for more details.

When Coverage Ends

Your eligibility for benefits may end for any of the following reasons:

- you die;
- you or your covered dependents no longer meet the Fund's eligibility requirements;
- the Fund or insurance company terminates the contract that provides your benefits;
- you or your covered dependents make a false statement on an enrollment form or a claim form, or otherwise engage in fraud; or
- your dependents' coverage will end on the date your coverage ends or on the date they no longer qualify as eligible dependents under the plan, whichever occurs first.

Your HIPAA Rights

When your Fund coverage ends, under the federal law known as HIPAA, you and/or your dependents are entitled by law to, and 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 buy 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; or
- 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.

Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the plan would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to the health care benefits (i.e., prescription drug, dental, vision and hearing aid) described in this booklet.

Qualifying COBRA events. The chart below shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue.

If You Lose Coverage Because	These People Would Be Eligible	For COBRA Coverage Up To
Your employment terminates*	You and your covered dependents	18 months**
Your working hours are reduced	You and your covered dependents	18 months**
You are on active military leave	You and your covered dependents	18 months
You die	Your covered dependents	36 months
You divorce	Your covered ex-spouse	36 months
Your dependent Children no longer qualify as eligible dependents	Your covered dependent Children	36 months

* For any reason other than gross misconduct.

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

Newborn Children. If you have a newborn child, adopt a child, or have a child placed with you for adoption while your continued coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 30 days of the child's birth, adoption or placement for adoption.

FMLA leave. If you are on an FMLA leave of absence, you will not experience a qualifying event. However, if you do not return to active employment after your FMLA leave of absence, you will experience a qualifying event of termination of employment. The qualifying event of termination of employment will occur at the earlier of the end of the FMLA leave or the date that you give notice to your employer that you will not be returning to active employment.

Multiple qualifying events. If your covered dependents experience more than one qualifying event while COBRA coverage is still in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event.

For example, if you terminate employment, you and your covered dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. The two periods combined may not exceed a total of 36 months from the date of your termination (the first qualifying event).

Notice of COBRA eligibility. Both you and the Fund Office have responsibilities when qualifying events occur that make you or your covered dependents eligible for continued coverage.

Your family should notify the Fund Office in the event you die. You or your eligible dependents are responsible for informing the Fund Office of a divorce, a child losing dependent status, or a determination of Social Security disability within 60 days of the date of the event. If you do not notify the Fund by the end of that period, your dependents will *not* be entitled to continued coverage. After the Fund has been notified of a qualifying event, it will send you information about your COBRA rights. You will have 60 days to respond if you want to continue coverage. If you do not elect COBRA coverage, your coverage will end.

Paying for COBRA coverage. If you or a covered dependent chooses to continue coverage under COBRA, you or your covered dependent have to pay the full cost of continued coverage under COBRA plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, your premium may increase to 150% of the full cost of continued coverage during the 19th to 29th months of coverage. Your first payment must be made within 45 days after you elect to continue coverage. All subsequent payments will be due on the first day of each month for that month's coverage. You will be notified in advance by the Fund Office if the amount of your monthly payment changes.

When COBRA coverage ends. COBRA coverage for you and/or your covered dependents may end for any of the following reasons:

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

Once your COBRA coverage ends for any reason, it cannot be reinstated.

Certificate of creditable coverage. When your COBRA continuation coverage ends, you will be provided with a Certificate of Creditable Coverage. The certificate may help reduce or eliminate any pre-existing condition exclusion when you enroll in another health plan. The Certificate of Creditable Coverage is part of federal HIPAA legislation.

COBRA claims. Claims incurred by you will not be paid unless you have elected COBRA coverage and pay the premiums, as required by law.

Summary. This description of your COBRA rights is only a general summary of the law. The law itself must be consulted to determine how the law would apply in any particular circumstance.

If you have any questions about eligibility, call the Fund Office at 212-366-7300 or 800-529-3863.

Continuation Under State Law

If you are not entitled to continued coverage under COBRA, you may be entitled to continuation of coverage under the provisions of your state insurance law.

PRESCRIPTION DRUG PROGRAM

How the Plan Works

The plan provides coverage for prescription drugs purchased at a participating pharmacy, a non-participating pharmacy, or through a mail-order pharmacy. Coverage depends on which option you use. You will receive an ID card when your coverage starts. The following table summarizes these benefits.

Summary of In-Network Prescription Drug Benefits

Prescriptions from a participating pharmacy (up to 34-day supply)	Benefit
Generic drugs	Plan pays 100% (no copay required)
"Single source" brand-name drugs (no generic equivalent)	You have a $6 copay and the plan pays the balance
Brand-name drugs with generic equivalents	You pay a $6 copay, plus the difference between the brand-name cost and generic cost; the plan pays the balance
Prescriptions through the mail-order program (up to 90-day supply)	**Benefit**
Generic drugs	Plan pays 100% (no copay required)
All brand-name drugs	You pay a $6 copay and plan pays the balance

Network of Participating Pharmacies

The Fund has contracted with Caremark to provide a network of participating pharmacies. These pharmacies are located nationwide, and currently include K-Mart, Walgreens, CVS, Rite Aid, Revco and Genovese. Before you have a prescription filled, check to make sure the pharmacy is part of the Caremark network. You don't need to file a claim when you use a participating pharmacy. You simply show your ID card and pay the applicable copay.

Using generic, instead of "brand-name," drugs usually saves money.

If you have any questions about the Caremark network or your prescriptions, or if you need an identification card, you may call Caremark directly at 800-378-0972. Customer Service Representatives are available to help you Monday through Friday from 8:30am to 10:00pm eastern time, and on Saturday from 9:00am to 1:00pm eastern time. Claim forms are available from Caremark and the Fund Office.

Out-of-Network Pharmacies

If you go to an out-of-network pharmacy, you must pay the full cost when you pick up the prescription and then file a claim for reimbursement with Caremark. The plan will pay you the discounted amount that would have been paid to a network pharmacy. You are responsible for any difference between the Caremark network discount price and what your pharmacy charged, plus the applicable copay.

When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date, the amount, the name, the strength and the quantity of the medication. Keep a copy of your completed claim form and the receipt for your records.

Claim forms for out-of-network pharmacy benefits are available from Caremark or the Fund Office.

See the section called "Claims and Appeals Procedures" for additional information on filing claims, and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

You can receive a larger supply of medication at a lower cost when you use the mail-order program.

Mail-Order Program

This program offers a greater discount on the cost of maintenance medication and a larger supply (90 days) per prescription. Maintenance drugs are those you must take every day for the treatment of a chronic condition, such as diabetes, asthma or high blood pressure.

Since only one copay is required for a 90-day prescription obtained through the mail-order program (as opposed to one copay for a 34-day supply from a pharmacy), you save when you use the mail-order program.

To use the mail-order program, simply mail your original prescription, your copayment (check or money order), if applicable, and a completed order form to Caremark. Your prescription will be delivered to your home via UPS or first class mail within 10–14 days after Caremark receives the order form. You will also receive a new mail-order form to be used for your next mail-order prescription or refill. Please allow sufficient time for receipt of your medication.

Forms for the mail-order program are available from both Caremark and the Fund Office.

Expenses Not Covered

Prescription drug benefits are **not** paid for:

- Drugs and/or medications:
  - ☐ Obtained after the date coverage ends for you or your dependents;
  - ☐ Filled for more than a 34-day supply at a retail pharmacy or a 90-day supply through mail order;
  - ☐ That are experimental and/or investigational, which means they are not approved by the Food and Drug Administration (FDA) and are not legally available for distribution;
  - ☐ For which your cost is equal to or less than the copay;
  - ☐ Received while confined in a hospital (however, these costs are covered by your medical plan);
  - ☐ Dispensed for a purpose other than the treatments recommended by the FDA;
  - ☐ Prescribed as a result of an Injury or illness covered by Workers' Compensation; or
  - ☐ Intended as nutritional or diet supplements;
- Psychotropic, injectable, chemotherapy and asthma medications for individuals who are not eligible for Medicare (these "PICA" drugs may be covered under a separate program sponsored by the City of New York);
- Refills exceeding the number your physician prescribes;
- Refills more than one year after the date of the original prescription;
- Non-legend drugs or medications;
- Over-the-counter drugs or medications;
- Immunization agents, vaccines, biological sera, blood or blood plasma;
- Fertility medications;
- Growth hormones, except when Medically Necessary and pre-authorized;
- Alcohol wipes;
- Renova;
- Retin-A, except when Medically Necessary;
- Vitamins available without a doctor's prescription; and
- Syringes for dispensing prescribed medication (these are covered by your medical benefit).

Clinical Intervention

Caremark provides a clinical intervention process to help guard against drug interaction problems that can occur, for example, when different medications are prescribed by more than one physician or specialist. A registered pharmacist will discuss alternative medications with your doctor and notify you of any change in your prescribed medication. However, your doctor makes the final decision on all of your prescribed medications.

A clinical intervention pharmacist may also (1) suggest changing to a "formulary" drug or (2) call your doctor if the prescription instructions are different from the drug manufacturer's instructions. "Formulary drug" means a drug recommended as a generic substitution or therapeutic equivalent to, and more cost effective than, an alternative prescribed drug.

DENTAL COVERAGE

How the Plan Works

Dental benefits, which are provided by the Fund and administered by Self-Insured Dental Services Inc. (S.I.D.S.), provide you with the option of going to any dentist or selecting from a panel of "participating dentists." However, whether you go to a participating or a non-participating dentist, all benefits are paid according to a "schedule of allowances" that provides a set fee for a particular procedure.

This coverage is designed to encourage regular checkups and preventive care and to correct minor dental problems before they become serious. Benefits are provided for diagnostic and preventive services, basic restorative services, major restorative services, bridges and dentures, periodontal treatment and oral surgical procedures. Orthodontic services are also provided.

Basic and major dental services are subject to a $100 annual deductible, and all dental services are subject to a maximum Fund payment of $2,500 per person per calendar year. You and your dependent Children are covered for orthodontic treatment up to a maximum Fund payment of $1,950 per lifetime.

The following chart summarizes the procedures and costs covered.

OVERVIEW OF DENTAL COVERAGE
Procedures Covered
DIAGNOSTIC AND PREVENTIVE SERVICES — routine procedures, such as oral examinations, bitewing X-rays, and adult/child prophylaxis (cleaning).
BASIC SERVICES — commonly used procedures, such as amalgam fillings, simple extractions, and root canals.
MAJOR SERVICES — complex extractions, periodontal treatment, extraction of impacted teeth, gum surgery, crowns, inlays, fixed bridgework, removable dentures and repairs to bridgework and dentures.
ORTHODONTIC SERVICES — correction of a handicapping malocclusion, including an initial examination, insertion of appliance and monthly treatment visits.

Network of Participating Dentists

You save money when you use dentists who are part of the S.I.D.S. network. These dentists have agreed to accept the payment provided under the Fund's schedule of allowances as payment in full (although you still have to meet any applicable deductible). For information about providers in your area, call S.I.D.S. at 516-396-5500, 718-204-7172, or toll-free at 877-592-1683, or visit their website, at **www.asonet.com**.

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

- diagnostic and preventive dental services are covered in full by the Fund in accordance with the plan's schedule of maximum allowances; and
- once you meet the deductible, basic and major restorative services are covered in full by the Fund up to the plan's maximum allowance.

If You Go to a Non-Participating Dentist

If you go to a non-participating dentist, you or your dentist will be reimbursed according to the plan's schedule of allowances. The charges of non-participating dentists may be higher than the plan's scheduled allowances. You are responsible for any difference between the amount your dentist charged and the amount the plan pays.

Pre-Treatment Estimate

This process is intended to inform you and your dentist, in advance of treatment and before any expenses are incurred, what benefits are provided by the plan.

It is recommended that a pre-treatment estimate be filed by your dentist if your dental care is going to cost more than $300 in a 90-day period or includes any of the following services: crowns, bridges, dentures, orthodontics, inlays or periodontal surgery.

To get a pre-treatment estimate, ask your dentist to describe the treatment plan and expected cost on a claim form. X-rays are required for treatment involving root canal therapy, inlays, crowns, bridges, dentures, and periodontal surgery. Submit the completed form to:

Self-Insured Dental Services
P.O. Box 9007, Dept. 95
Lynbrook, NY 11563-9007

S.I.D.S. will review the proposed treatment and will send you and your dentist an explanation of benefits form that indicates the amount the plan will pay for each procedure and identifies services that are not covered or not payable by the program.

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

Orthodontic Services

A dentist must diagnose the need for orthodontic services and must indicate that the orthodontic condition consists of a handicapping, abnormal, correctable malocclusion. **Before treatment begins, S.I.D.S. should estimate what the plan allowance for orthodontic services will be under the pre-treatment estimate program.**

Orthodontic benefits include:

Orthodontic Service	Benefit
Diagnosis and insertion of orthodontic appliances	$450
Active treatment, up to a maximum of 24 months	$50 per month
Retention treatment following active treatment, up to a maximum of 18 months	$100 per six months

These orthodontic benefits are not subject to the annual deductible, nor do they count toward your annual maximum.

Extension of Dental Benefits

If your or your dependent's eligibility terminates in the course of certain dental treatment, and you received a pre-treatment estimate for these procedures, the patient's dental coverage will be extended for up to 90 days after eligibility would otherwise end so that the work can be completed. This limited extension applies to the following procedures only:

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

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

Schedule of Covered Dental Allowances

The chart below lists all dental services covered by the plan, and the maximum amount the plan will pay for each service. Remember: participating providers have agreed to accept the plan payment as payment in full, except for the $100 annual deductible.

DIAGNOSTIC & PREVENTIVE	
	PLAN PAYS
ORAL EXAMINATION maximum: two per calendar year	$15.00
FULL-MOUTH SERIES X-RAYS 10 to 14 periapical/bitewing films	30.00
PANORAMIC FILM	30.00
PERIAPICAL OR BITEWING, per film	4.00
OCCLUSAL FILM	13.00
CEPHALOMETRIC FILM	34.00
POSTERIOR–ANTERIOR FILM	29.00
LATERAL FILM	32.00
TEMPOROMANDIBULAR FILM X-ray maximum: $50 per calendar year	40.00
PROPHYLAXIS, including scaling and polishing adult child, to age 15 maximum: two per calendar year	 28.00 25.00
FLUORIDE TREATMENT excluding prophylaxis to age 15, two per calendar year	18.00
SEALANT Unrestored permanent posterior teeth only, to age 15 Lifetime maximum: $45 per quadrant	15.00
SPACE MAINTAINER acrylic metal	 98.00 135.00

BASIC RESTORATIVE	
	PLAN PAYS
SILVER AMALGAM FILLINGS	
one surface – primary	$25.00
two surfaces – primary	35.00
three or more surfaces – primary	48.00
one surface – permanent	35.00
two surfaces – permanent	45.00
three surfaces – permanent	55.00
four or more surfaces – permanent	65.00
COMPOSITE RESIN—ANTERIOR	
one surface	35.00
two surfaces	45.00
three surfaces	60.00
four or more and incisal angle	60.00
COMPOSITE RESIN—POSTERIOR	
one surface	40.00
two surfaces	50.00
three surfaces	60.00
MAJOR RESTORATIVE Preoperative periapical X-ray required. There is a five-year frequency limitation on replacements.	
CROWNS	
plastic	$120.00
porcelain jacket	325.00
plastic with metal	325.00
porcelain with metal	375.00
full cast	350.00
METALLIC INLAY	
one surface	200.00
two surfaces	250.00
three surfaces	300.00
PORCELAIN INLAY	
one surface	200.00
two surfaces	250.00
three surfaces	300.00
STAINLESS STEEL CROWN, primary tooth	100.00
CAST POST & CORE	100.00
PREFAB POST & CORE	86.00
ENDODONTICS X-ray evidence of satisfactory completion required.	
PULPOTOMY	$75.00
ROOT THERAPY	
one canal	200.00
two canals	250.00
three canals	325.00
four or more canals	375.00
APICOECTOMY	130.00
APICOECTOMY – max per tooth	260.00
RETROGRADE FILLING	60.00

PROSTHODONTICS
Preoperative X-rays are required when filing a claim for pretreatment review or payment on all prosthetics. X-rays of the full arch must be included for all bridgework. There is a five-year frequency limitation from date of installation on all prosthetics.

	PLAN PAYS
COMPLETE DENTURE immediate or permanent	 $400.00
PARTIAL DENTURE—UNILATERAL	240.00
PARTIAL DENTURE—BILATERAL acrylic base with clasps and rests cast metal base	 325.00 400.00
PRECISION ATTACHMENT	100.00
BRIDGE PONTIC full cast plastic with metal porcelain with metal	 300.00 300.00 375.00
ABUTMENT—INLAY TWO SURFACE	250.00
ABUTMENT—INLAY THREE SURFACE	300.00
CAST METAL RETNR-ACID ETCH BRIDGE	200.00
BRIDGE ABUTMENT crown – plastic with metal crown – porcelain fused to metal crown – full cast	 325.00 375.00 300.00
DENTURE RELINE—CHAIR	80.00
DENTURE RELINE—LABORATORY	125.00
DENTURE REPAIRS denture adjustment repair cast framework repair complete denture base replace tooth in denture replace broken facing add tooth to existing partial denture	 25.00 95.00 70.00 65.00 100.00 65.00
RECEMENT CROWN OR INLAY	25.00
RECEMENT BRIDGE	30.00
SURGICAL PLACEMENT OF IMPLANT	1,200.00
CUSTOM IMPLANT ABUTMENT Only payable if fabricated and placed by dentist other than provider placing the implant	200.00

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

	PLAN PAYS
ROOT SCALING, GINGIVAL CURETTAGE & BITE CORRECTION, INCLUDING PROPHYLAXIS, per quadrant	$50.00
two or more quadrants per visit	75.00
periodontal maintenance	60.00
maximum allowance on any combination of the above services is $200 in a calendar year	
PERIODONTAL SURGERY confirmation by charting and/or X-rays required per quadrant of at least five teeth	
localized delivery of chemotherapeutic agent maximum allowance $150 per quadrant	50.00
gingivectomy, gingivoplasty and mucogingival surgery per quadrant	150.00
osseous surgery, including gingivectomy – per quadrant	375.00
osseous graft, per quadrant	300.00
ORAL SURGERY	
ROUTINE EXTRACTION	$40.00
SURGICAL EXTRACTION must be demonstrated by X-ray	
erupted tooth	65.00
impaction – soft tissue	100.00
impaction – partial bony	175.00
impaction – complete bony	200.00
ALVEOLOPLASTY—PER JAW	125.00
BIOPSY OF ORAL TISSUE—HARD TISSUE	100.00
REMOVAL OF CYST OR TUMOR <1.25	75.00
REMOVAL OF CYST OR TUMOR >1.25	100.00
FRENULECTOMY	95.00
ORTHODONTICS	
INITIAL FIXED APPLIANCE	$450.00
ACTIVE TREATMENT—PER MONTH maximum of 24 months	50.00
POST-TREATMENT STABILIZATION DEVICE	110.00
PASSIVE TREATMENT—PER SIX MONTHS maximum of 18 months	100.00
MINOR TOOTH MOVEMENT	
removable acrylic appliance	80.00
removable metal appliance	225.00
fixed acrylic appliance	75.00
fixed metal appliance	80.00

ADJUNCTIVE SERVICES	
	PLAN PAYS
PALLIATIVE TREATMENT – no other treatment that visit	$30.00
GENERAL ANESTHESIA – plan pays first 30 minutes only	110.00
BRUXISM APPLIANCE	225.00
SPECIALIST CONSULTATION – includes examination	50.00
BEHAVIOR MANAGEMENT – only when rendered by a participating pedodontist in conjunction with other treatment only	50.00
TOOTH WHITENING – per arch must be provided by a licensed dentist using materials and equipment specifically designed to accomplish tooth whitening in a one-visit chairside setting on natural, unrestored teeth. All other tooth-whitening products or take-home methods, including those provided by a dentist, are not covered. **Lifetime Maximum** – one treatment per arch	150.00

How to File a Claim

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

Non-Participating Dentist. When you use a dentist who is not a participating provider, you or your dentist should file a claim form with S.I.D.S. Claim forms are available from S.I.D.S. or the Fund Office. When you use a non-participating dentist, you are responsible for the difference between your dentist's charges and the maximum amount listed in the Schedule of Covered Dental Allowances. Completed forms, whether the services are provided by a participating or a non-participating dentist, should be sent to:

Self-Insured Dental Services
P. O. Box 9007
Lynbrook, NY 11563-9007

See the section called "Claims and Appeals Procedures" for additional information on filing claims, and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Exclusions and Limitations

There is no coverage for:

- any charges that exceed the amounts shown in the Schedule of Covered Dental Allowances;
- treatment for the purpose of cosmetic improvement;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown, inlay or denture within five years after the date it was originally installed;
- any replacement of a bridge, crown, inlay or denture which can be made usable according to accepted dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to:
  - ☐ change vertical dimension;
  - ☐ diagnose or treat conditions or dysfunctions of the temporomandibular joint (this coverage may be covered under your medical benefits); or
  - ☐ stabilize periodontally involved teeth;
- periodontal splinting;
- multiple bridge abutments;
- a surgical implant of any type;
- over-the-counter analgesia;
- services that do not meet accepted dental standards;
- services not included in the Schedule of Covered Dental Allowances;
- services or supplies resulting from an accidental Injury, and which are deemed to be the responsibility of a third party;
- any care which is covered under Workers' Compensation or a similar law, or for an Injury arising out of, or in the course of, any employment for wage or profit;

- charges made by a hospital owned or run by the United States government, unless you would be obligated to pay the charges even if you had no insurance;
- services for which payment is unlawful where the person resides when the expenses are incurred;
- services for which there would be no charge in the absence of this coverage, including services provided by a member of the patient's immediate family;
- charges for unnecessary care, treatment or surgery;
- any charges that are paid for by a government program; and
- experimental procedure or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Important Definitions

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

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

Non-participating dentist — A dentist who does not have an agreement with S.I.D.S. to accept the Fund's maximum allowance as payment in full for covered services.

VISION BENEFITS

Vision benefits are provided through three networks of providers — Comprehensive Professional Systems (CPS), 212-675-5745, General Vision Services (GVS), 800-847-4661 and Vision Screening, 800-652-0063. You may use any of these networks for your vision services, or you may use a non-network provider. Selections of frames and lenses may vary among the three networks and, in some instances, among locations in the same network.

Benefits

If you are eligible for vision benefits, you and your covered dependents are entitled to an eye examination and new glasses or contact lenses once every 12 months. If you use a participating provider, there are no out-of-pocket costs if the frames and lenses you select are part of the program. If the frames and lenses you select are outside the program, you receive a credit toward your purchase.

Covered Services

The Fund pays a participating provider $125 for an exam and a pair of frames and lenses. If you use a non-participating provider, the Fund will reimburse you up to $125 for the same package of services.

You can obtain a list of participating providers from the Fund Office at 800-529-3863.

Costs

Some services that you receive from participating providers require that you pay a portion of the cost. These services and their cost are listed below. If you receive any of these services on an out-of-network basis, you will be responsible for any cost above your $125 allowance.

Service	Your Cost at CPS	Your Cost at GVS	Your Cost at Vision Screening
Scratch-resistant coating, single vision	$10	$10	No charge
Scratch-resistant coating, bifocal or trifocal	$15	$15	No charge
High-index single-vision plastic lenses	$50	No charge	$50
High-index bifocal plastic lenses	$70	No charge	$50
Polycarbonate single-vision lenses	$70	$70	$30
Polycarbonate bifocal lenses	$100	$100	$75
Reflection-free coating	$40	$40	$35
Transition single-vision lenses	$75	$ 75	$70
Transition bifocal/multifocal lenses	$100	$100	$90
Hyper-index	$125	$125	$125

How to File a Claim

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

Non-network provider. When you use a provider who is not in the CPS, GVS or Vision Screening network, you must pay the full fee and submit a claim to the Fund Office for reimbursement. The Fund will pay only the amount it would have paid had you gone to a participating provider (up to $125 for an exam and a pair of frames and lenses).

See the section called "Claims and Appeals Procedures" for additional information on filing claims, and for procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

LIFE INSURANCE

The Fund provides basic and dependent life insurance benefits at no cost to you. This coverage is provided and insured through the Union Labor Life Insurance Company ("ULLICO").

How the Plan Works

If you die while you are an Active Employee, your Beneficiary will receive a life insurance payment equal to $25,000. (However, the amount of your life insurance will be reduced by any accelerated death benefit paid. The accelerated death benefit is described later.)

If you are an eligible Retiree, your coverage will continue in the amount of $6,000. There is no cost to continue life insurance coverage as a Retiree.

Naming a Beneficiary

You must name a Beneficiary for your life insurance. Your Beneficiary may be one or more person(s), a trust, an estate, a charity, etc. In addition to naming a Beneficiary, you can also designate a contingent Beneficiary. A contingent Beneficiary receives benefits in the event the primary Beneficiary dies before you.

You may change your Beneficiary at any time by submitting a new Beneficiary designation form to the Fund Office. Beneficiary designation forms are available from the Fund Office. It is important to keep your Beneficiary designation up to date.

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

- your surviving spouse or, if none,
- your Children in equal shares or, if none,
- your parents in equal shares or, if none,
- your brothers and sisters in equal shares or, if none,
- your estate.

Accelerated Death Benefit

If you're an Active Employee, you may elect to have a minimum of 25% and a maximum of 50% of your life insurance benefits paid to you while you are still living if:

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

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

To apply for an accelerated death benefit, send a written request to the Fund Office. The insurance company will require a doctor's written certification that you are terminally ill with a life expectancy of six months or less (ULLICO may require an independent exam). You cannot be required to request accelerated death benefits to pay creditors, or to qualify for a government benefit or entitlement.

Converting to an Individual Policy

If your life insurance with the Fund ends, you may convert all or a portion of your coverage to an individual plan. You must apply for an individual policy and pay the first month's premium within 31 days after your Fund insurance ends. To apply for conversion coverage, contact ULLICO directly.

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

How to File a Claim

If you die, your Beneficiary or family member should contact the Fund Office within 20 days to obtain a claim form. A Fund Office representative will provide any necessary forms within 15 days. If the forms are not provided within 15 days, you may submit any other written proof that describes the nature and extent of your claim. In addition to completing a claim form, your Beneficiary will be asked to provide proof of your death. Generally, the Fund Office will accept an original death certificate as proof of death. A life insurance claim must be filed within two years of the date of death.

In the section called "Claims and Appeals Procedures" there's additional information on filing claims, and the procedures to follow in appealing a claim that is wholly or partially denied.

SHORT-TERM DISABILITY BENEFITS (FOR ACTIVE EMPLOYEES ONLY)

How the Plan Works

This plan will pay you a weekly benefit if you become disabled and unable to work as the result of an Injury or illness that is not work-related. There is no short-term disability insurance for Retirees or for dependents.

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

When Coverage Begins

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

When Benefits Begin

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

"FICA" taxes will be withheld from any disability benefits due you.

Your Benefits

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

How to File a Claim

Call the Fund Office toll-free at 800-529-3863 to obtain a claim form as soon as you stop working. Return the completed form to the Fund Office along with copies of your pay stubs for the eight-week period immediately prior to your disability. Be sure to keep a copy of your claim form and bills for your own records. The Fund retains the right to ask for evidence of continued disability at any time, or to require you to see a doctor of the Fund's choosing at the Fund's expense.

See the section called "Claims and Appeals Procedures" for additional information on filing claims, and procedures to follow if your claim is wholly or partially denied and you wish to appeal the decision.

Work-Related Disabilities

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

HEARING AID BENEFIT

You and your covered dependents are eligible for a hearing aid benefit once every four years. You may receive benefits from any hearing aid provider. However, you will receive the highest level of coverage when you use the network of participating providers affiliated with Comprehensive Professional Systems (CPS) or General Vision Services (GVS).

Covered Services

At a network location. Although you may obtain benefits at any provider, GVS and CPS have negotiated special discounts on your behalf. For a listing of providers that participate in the CPS or GVS networks, call GVS toll-free at 800-847-4661 or CPS at 212-675-5745. Coverage is provided at no cost to you at a CPS provider and for a $150 copayment at a GVS provider for the following:

- a hearing evaluation;
- a behind-the-ear, in-the-ear or otosonic hearing aid, or any comparable manufacturer's hearing aid;
- a battery for your hearing aid, with a one-year guarantee; and
- unlimited servicing of your hearing aid for one year.

If you select a hearing aid that is not part of the Fund package, you may have to make additional payments.

When you go to a non-participating provider. You will have to pay for the services you receive and submit a claim to the Fund Office. The Fund will reimburse you the same amount it would have paid if you had gone to a network provider, up to a maximum benefit of $350.

Maximum Benefit

The maximum benefit is $350 per family member for each ear, once every four years.

How to File a Claim

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

Non-network provider. When you use a provider that is not in the CPS or GVS network, you must pay the full fee and submit a claim to the Fund Office for reimbursement. Complete the section of the claim form that asks for information about you or your covered dependent, and ask your provider to complete the rest of the claim form or provide you with an itemized bill that contains the same information requested on the form. Be sure to keep a copy of your claim form and bills for your own records.

See the section called "Claims and Appeals Procedures" for additional information on filing claims, and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

SCHOLARSHIP PROGRAM

The Fund offers a Scholarship Program for unmarried dependent Children of eligible members (including both natural or legally adopted children). For purposes of the Scholarship Program, these children are all referred to as "Qualifying Children." The Scholarship and Recognition Programs, an independent and professional organization of the Educational Testing Service of Princeton, New Jersey, administers the Scholarship Program.

Eligibility

Your Child's eligibility for this benefit depends, first, on your eligibility. You are eligible if you are working or have worked for an employer who is obligated to make contributions to the Welfare Fund for the Scholarship Program on your behalf and you meet the eligibility requirements listed below:

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

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

How the Plan Works

This benefit is a Scholarship Program for unmarried, dependent, natural or legally adopted Children, regardless of age, who:

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

If you are a Retiree, your Qualifying Children are eligible for this program if you met the Active Employee requirements at the time of your retirement.

If you are a Recovered Disability Pensioner, your Qualifying Children are eligible for this program provided you return to Covered Scholarship Employment for at least 1,000 hours, including at least 500 hours in the calendar year immediately preceding the September for which the scholarship is to be first awarded and meet the requirements for an Active Employee as previously described, except that the number of calendar years in the appropriate eligibility test period may exclude those in which total and permanent disability, as recognized by the New York City District Council of Carpenters Welfare Fund, existed.

Qualifying Children of deceased participants are eligible if the member had met the Active Employee requirements at the time of his death.

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

The Benefit

The Scholarship Program pays up to $3,500 for each year of a four-year academic program at an accredited college or university, or until the child receives a bachelor's degree, whichever occurs first.

The maximum amount of the award is $14,000 per student.

Any other financial assistance (e.g., awards, aid, loans) received by your child must be reported to the Fund Office. The Scholarship Program adjusts the scholarship so that the combination of awards does not exceed total tuition, room and board expenses, and usual fees. New York State Regents awards, however, are not considered.

How to Apply

September. Call the Fund Office at 212-366-7300 in the beginning of the September of your child's senior year in high school to request an application.

November. By mid-November of your child's senior year in high school, submit the completed application to the Fund Office.

December. By December of your child's senior year in high school, your child needs to take the Scholastic Assessment Tests (SATs). **Your child needs to write "Code 0028" on the registration form for the SATs, so that the test scores will be sent to the Scholarship and Recognition Programs for their files.**

Appealing a Denied Application

If your application is denied, you may appeal the decision by filing a request for review by the Board of Trustees. Your request must be filed within 30 days after the application was denied and will be reviewed at the next quarterly Board of Trustees meeting (unless the request is received within 30 days of that meeting, in which case it will be reviewed at the second following Board of Trustees meeting).

Selection Process

An independent and professional education organization of the Educational Testing Service of Princeton, New Jersey, the Scholarship and Recognition Programs consider a number of factors in awarding scholarships: the student's high school academic record, SAT scores, moral character, leadership qualities, and seriousness of purpose. The number of scholarships awarded is at the Trustees' sole discretion.

For Further Information

If you need additional information about the Scholarship Program, call the Fund Office at 212-366-7300.

COORDINATION OF BENEFITS

Coordination of Benefits

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

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

Which Plan Pays Benefits First?

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

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

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

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

When the parents are divorced or separated:

- If there is no court decree establishing financial responsibility for the child's health care expenses, the plan covering the parent with custody is primary.
- If the parent with custody is remarried, his or her plan pays first, the stepparent's plan pays second and the non-custodial parent's plan pays third.
- If there is a court decree specifying which parent has financial responsibility for the child's health care expenses, that parent's plan is primary, once the Fund Office knows about the decree.

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

If Our Plan Is the Secondary Plan

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

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claim under each plan.
- File claims first with the primary plan, then with the secondary plan.
- Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

CONFIDENTIALITY

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

The Welfare Fund operates in accordance with the regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with respect to protected health information. A complete description of your rights under HIPAA is available in the Fund's Notice of Privacy Practices. The following statement is merely a summary of the key provisions of the Fund's Notice of Privacy Practices.

The term "protected health information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental condition or payment for health care. PHI includes all information maintained by the Fund in oral, written or electronic form (except for any information that is received in connection with the life insurance, accidental death and dismemberment benefits or disability benefits).

The Fund and the Board of Trustees are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- The Fund will disclose protected health information to the Board of Trustees only for the Trustees' use in plan administration functions, unless the Trustees have your written permission to use or disclose your protected health information for other purposes.
- The Fund has in place safeguards to protect the confidentiality, security and integrity of your health information. Protected health information that is received by the Board of Trustees from the Fund, will not be used or disclosed other than as permitted or required by this summary plan description, or as required by law, or at the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Fund.
- The Board of Trustees will not disclose your protected health information to any of its Providers, agents or subcontractors unless the Providers, agents and subcontractors agree to keep your protected health information confidential to the same extent as is required of the Board of Trustees.

- The Board of Trustees will not use or disclose your protected health information for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the Board of Trustees without your specific written permission.
- The Fund may disclose protected health information to external vendors for purposes of health care management in accordance with appropriate confidentiality agreements. Data shared with external entities for measurement purposes or research will be released only in an aggregate form that does not allow direct or indirect member identification. Identifiable personal information may not be shared with the Fund Office, unless required by law.
- The Board of Trustees will report to the Fund's Privacy Officer any use or disclosure of protected health information that is inconsistent with the Fund's Privacy Policy.
- The Board of Trustees will allow you, through the Fund, to inspect and photocopy your protected health information, to the extent, and in the manner, required by HIPAA.
- The Board of Trustees will make available to the Fund your protected health information for amendment and incorporation of any such amendments to the extent, and in the manner, required by HIPAA.
- The Board of Trustees will keep a written record of certain types of disclosures it may make of protected health information, so that the Fund can maintain an accounting of disclosures of protected health information.
- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of protected health information received from the Fund in order to allow the Secretary to determine the Fund's compliance with HIPAA.
- The Board of Trustees will return to the Fund or destroy all protected health information received from the Fund when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the protected health information, then the Trustees shall limit their further use or disclosures of any of your protected health information that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

- The Board of Trustees shall ensure that adequate separation will be maintained between the Fund. Only the categories of employees enumerated hereafter and individual Trustees will be permitted to have access to and use the protected health information to perform plan administration functions. The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or on behalf of the Board of Trustees: the Fund Director, the Assistant Fund Manager and all other Welfare Fund claims staff routinely responsible for administration of claims for the Fund. Additionally, individual Trustees may receive health information from the Fund in the course of hearing appeals or handling other plan administration functions.

- If the Board of Trustees becomes aware of any noncompliance with the provisions outlined above by any of the employees listed above, the Board of Trustees will promptly report the violation to the Fund's Privacy Officer and will cooperate with the Fund to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual(s) whose privacy has been violated.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits from the New York City District Council of Carpenters Welfare Fund. It also describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. The claims procedures will vary depending on the type of your claim. The Welfare Fund has contracted with a number of health organizations ("Health Organization") to administer the different benefits components. Read each of the following sections carefully to determine which procedure is applicable to your particular request for benefits. The effective date of these procedures is July 1, 2002. These procedures supersede any prior version.

What Is a Claim

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

What is not a claim:

- A request for prior approval of a benefit that does not require prior approval by the plan is not a claim for benefits.
- An inquiry about plan eligibility that does not request benefits is not a claim for benefits.
- A request for verification of whether a particular service is covered under the plan is not a claim for benefits.
- The presentation of a prescription to a pharmacy to be filled under the terms of the plan is not a claim for benefits.
- A request made by someone other than the claimant or his or her authorized representative is not a claim for benefits.

Types of Claims

Precertification. Prior approval of services may be required for certain medical services under the plan. Please refer to each specific section of this plan for more information on precertification. If you fail to precertify these services, no plan benefits will be payable for the services.

Urgent. An Urgent Care Claim is when the plan requires precertification of a benefit with respect to medical care or treatment where applying non-urgent timeframes:

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

Concurrent. If the plan has approved an ongoing course of treatment covering either a period of time or a number of treatments, any reduction or termination before the end of the approved treatment is a concurrent care decision.

Retrospective. A retrospective request is any claim submitted for payment after the service or treatment has been rendered to you.

Disability. A disability claim is any claim that requires a finding of total disability as a condition of eligibility for a benefit. The Fund reserves the right to have a physician examine you (at the Fund's expense) as often as is reasonable while a claim for disability benefits is pending.

Life insurance. A life insurance claim is any claim for payment made by your beneficiary on the occasion of your death.

How to File a Claim

A claim form may be obtained from the Fund Office by calling 800-529-3863 or from the specific Health Organization listed later. The claim form should be completed in its entirety and submitted to the appropriate Health Organization. If a request is filed improperly or the form is incomplete, the request will not constitute claim under these procedures.

You will only receive notice of an improperly filed claim if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Check the claim form to be certain that all applicable portions of the form are completed. Include with the claim form any itemized bills if services have already been provided to you or any documentation requested to verify your claim. If the claim forms have to be returned to you for information, delays in processing the claim will result.

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

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim without you having to complete the special authorization form. If an authorized representative is designated, all notices will be provided to you through your authorized representative.

When Claims Must Be Filed

Claims should be filed in writing as soon as possible after the date the charges are incurred. Your claim will be considered to have been filed as soon as it is received by the appropriate Health Organization that is responsible for making the initial determination of the claim. Urgent claims, however, may not be submitted in writing, but must be submitted by telephone to the appropriate Health Organization.

Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than one year from the date the charges were incurred. Claims for life insurance benefits must be filed within two years of the loss.

Where to Submit Your Claims

The contact information for each Health Organization for you to use to submit initial claims is as follows:

Prescription Drug Claims

Caremark
P.O. Box 686005
San Antonio, TX 78268-6005
Telephone: 800-378-0972

Dental Claims

Self-Insured Dental Services (S.I.D.S.)
P.O. Box 9007, Department 95
Lynbrook, NY 11563-9007
Telephone: 877-592-1683

In-Network Vision Claims

If you go to a network provider, submit your name and Social Security number to the provider. The provider will submit the claim form to the Fund Office for payment.

In-Network Hearing Claims

If you go to a network provider, submit your name and Social Security number to the provider. The provider will submit the claim form to the Fund Office for payment.

Out-of-Network Vision Claims and Out-of-Network Hearing Claims

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

Short-Term Disability Claims

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

The Fund will review the claim for eligibility and completeness and then forward the claim to ULLICO at:

111 Massachusetts Ave., N.W.
Mail Stop 709
Washington, DC 20001
Telephone: 866-795-0680

Claims Review Process

After you submit a properly completed claim form, the Health Organization will review the claim and make a decision within the applicable time frames for decisionmaking.

Time Frames for Decisionmaking

The applicable Health Organization will comply with the following time frames in processing your claim, which vary depending on the type of claim submitted:

- **Precertification** — The Health Organization will review all requests for precertification within **15 days** of receipt of the request. If the Health Organization does not have enough information to make a decision within 15 days, it will notify you in writing as soon as possible but not later than 5 days after receipt of the claim of the additional information needed, and you and your provider will have 45 days to respond. The Health Organization will make a decision within 15 days of receipt of the requested information or, if no response is received, within 15 days after the deadline for a response.
- **Urgent precertification** — The Health Organization will review all requests for urgent precertifications within **72 hours** of receipt of the request. If further information is needed to make the decision, the Health Organization will notify you by telephone within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. Notice of the decision will be provided within 48 hours of receipt of the requested information or, if no response is received, within 48 hours after the deadline for a response.

- **Concurrent** — A claim to continue or extend treatment should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. The applicable Health Organization will complete all concurrent reviews of services as soon as possible but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

- **Retrospective** — The applicable Health Organization will complete all retrospective reviews of services already provided within **30 days** of receipt of the claim. If the Health Organization does not have enough information to make a decision within 30 days, it will notify you in writing, before the end of the initial 30-day period of the additional information needed, and you and your provider will have 45 days to respond. The Health Organization will make a decision within 15 days of receipt of the requested information or, if no response is received, within 15 days after the deadline for a response. If an extension is necessary due to matters beyond the Health Organization's control, it will notify you in writing, before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision, but the extension may be no more than 15 days.

- **Disability** — The Fund will complete its review of a disability claim within **45 days** of receipt of the claim. If an extension is necessary due to matters beyond the Fund's control, it will notify you in writing, before the end of the initial 45-day period of the date by which it expects to render a decision. The Fund will make a decision within 30 days of the time it notifies you of the delay, or an additional 30 days if it notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days to respond. During the period in which you are allowed to supply additional information, the Fund's 45-day period for making a decision will be suspended until either 45 days or the date you respond to the request (whichever is earlier). The Fund will make a decision within 30 days of receipt of the requested information or, if no response is received, your claim will be denied.

- **Life Insurance** — same as retrospective requests.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). A denial of a claim may also include any claim where the plan pays less than the total amount of expenses submitted regarding a claim. This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your claim, or a statement that it is available upon request at no charge.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

Internal Review Process

If your claim is denied in whole or in part, or if you disagree with the initial decision made on a claim, you may ask for a review by filing an appeal with the Health Organization. An appeal is a request to have the Health Organization reconsider a denial based on a finding that the service is not medically necessary or is considered to be experimental or investigational. A grievance is a request to have the Health Organization reconsider a denial based on any other terms of the plan.

How to File a Request for Review

Your request for review must be made in writing to the Health Organization within **180 days** after you receive notice of denial. If the appeal or grievance is not submitted within that time frame, the Health Organization will not review it and its initial decision will stand. The contact information for each Health Organization is provided below:

Dental Appeals

Self-Insured Dental Service (S.I.D.S.)
P.O. Box 9007, Dept. 95
Lynbrook, NY 11563-9007
Telephone: 516-396-5500, 718-204-7172
or 877-592-1683

Vision, Hearing, or Prescription Drug Benefit Appeals

The Board of Trustees
New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014
Telephone: 800-529-3863

Life Insurance Appeals

ULLICO
111 Massachusetts Ave., N.W.
Mail Stop 709
Washington, DC 20001
Telephone: 866-795-0680

Short-Term Disability Appeals

In NY State:
Workers' Compensation Board
Disability Benefits Bureau
100 Broadway – Menands
Albany, NY 12241

In New Jersey:
Division of Temporary Disability Insurance
Private Plan Operations
Claims Review Unit
P.O. Box 957
Trenton, NJ 08625

Your Rights in the Review Process

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

Time Frames for Appeals Decisionmaking

After you submit a request for review to the appropriate Health Organization, it will comply with the following time frames in processing your request for review, which vary depending on the type of initial claim submitted: For medical, hospital and dental retrospective requests, there are two levels of appeals and grievances with the applicable Health Organizations, plus a voluntary third level of appeal. For all other retrospective requests, there is one level of appeal described below.

S.I.D.S.

First Level. The Health Organization will comply with the following time frames in reviewing First Level appeals and grievances:

- Precertification — The Health Organization will complete its review of a precertification appeal within 15 days of receipt of the appeal.
- Urgent — If the need for the service is urgent, the Health Organization will complete the review as soon as possible, taking into account the medical circumstances, but in any event within **72 hours** of our receipt of the appeal. The determination will also be confirmed in writing no later than three days after the oral notification.
- Concurrent — The Health Organization will complete its review of a concurrent appeal within 15 days of receipt of the appeal; provided, however, that if the need for the service is urgent, it will complete the review as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the appeal.
- Retrospective — The Health Organization will complete its review of a retrospective appeal within **30 days** of receipt of the appeal.

Second Level. Your request must be received within 60 days of the date of the decision on your First Level appeal or grievance. If the appeal or grievance is not submitted within that time frame, the Health Organization will not review it and the decision on the First Level appeal or grievance will stand. The Health Organization will comply with the following time frames in reviewing Second Level appeals and grievances:

- Precertification — The Health Organization will complete its review of a precertification appeal within **15 days** of receipt of the appeal.
- Urgent — There is no second level of appeal for urgent precertification requests.
- Concurrent — The Health Organization will complete its review of a concurrent appeal within 15 days of receipt of the appeal; provided, however, that there is no second level of appeal for urgent concurrent requests.
- Retrospective — The Health Organization will complete its review of a retrospective appeal within **30 days** of receipt of the appeal.

Third Level. The third level of appeal is a voluntary procedure.

Should an adverse determination be made upon review of your claim by S.I.D.S., you will have an opportunity to choose a voluntary third level of appeal before the Board of Trustees. To request this third-level voluntary appeal, or if you have any questions, please call the Fund Office. This third level of appeal is not required by the plan and is only available if you or your authorized representative request it.

- The voluntary level of appeal is available only after you have pursued the appropriate mandatory appeals process required by the plan, as indicated previously in this section.
- The plan will not assert a failure to exhaust administrative remedies where you elect to pursue a claim in court rather than through the voluntary level of appeal.
- Where you choose to pursue a claim in court after completing the voluntary appeal, the plan agrees that any statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;
- Upon your request, the plan will provide you with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including specific information regarding the process for selecting a decisionmaker and any circumstances that may affect the impartiality of the decisionmaker.
- The plan will not impose fees or costs on you should you choose to invoke the voluntary appeals process.

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

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

Life insurance claims. ULLICO will make a decision within **60 days** following receipt of your request for a review.

Notice of Decision on Review

The decision on any review of your claim (both before and after the voluntary third level of appeal) will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination.
- Reference to the specific plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement describing the plan's voluntary appeal procedures and your right to obtain the information about such procedures.

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your claim, or a statement that it is available upon request at no charge.
- 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."

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. However, a lawsuit may be started prior to you requesting or submitting a benefit dispute to any voluntary third level of appeal. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the plan has failed to follow them.

GLOSSARY

Beneficiary	The Individual(s), trust or estate that you name to receive benefit under the Life Insurance and Accidental Death and Dismemberment insurance coverage, if you should die.
Children	Your eligible dependent Children include your biological child, adopted child (including a child who has been placed with you for adoption), or stepchild, as long as the child is unmarried and primarily dependent upon you for support and maintenance.
Covered Employment	means periods of employment when the City contributes to the Fund on your behalf.
Disabled Child or Children	A Disabled Child is an unmarried child of any age who is incapable of self-sustaining employment due to physical or mental handicap. The handicap must begin before age 19 or 25, when coverage for the child would usually end. Written evidence of the handicap must be sent to the Fund Office within 60 days of the date when coverage would usually end, and when requested by the Fund thereafter.
Injury	A bodily Injury resulting directly from an accident and independently of other causes, which occurs while you are covered under this plan.
Medically Necessary	Services, supplies or equipment provided by a hospital or other provider of health services are Medically Necessary if they are consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or Injury; in accordance with standards of good medical practice; not solely for the convenience of the patient or provider; not primarily custodial; and the most appropriate level of service that can be safely provided to the patient. The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it Medically Necessary.

OTHER THINGS YOU SHOULD KNOW

Plan Amendments or Termination

The Board of Trustees intends to continue the Welfare Fund indefinitely; however, they reserve the exclusive right to amend, modify, suspend, increase the cost of, or terminate the plan at any time, in accordance with the procedures specified in the Trust agreement. Upon termination of the plan, the Trustees shall apply the monies of the Fund to provide benefits or to otherwise carry out the purposes of the plan in an equitable manner, until the entire remainder of the Fund has been disbursed.

Representations

No local union officer, business agent, local union employee, employer or employer representative, Fund Office personnel, consultant or individual Trustee or attorney is authorized to speak for the Trustees or commit the Trustees on any matter relating to the plan, without the express authority of the Trustees.

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

Plan Interpretation

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

No Liability for the Practice of Medicine

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

PLAN FACTS

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

Trustees	Board of Trustees New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 212-366-7300
Participating Employers	The Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Welfare Fund on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and unions participating in the Welfare Fund may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.
Agent for Service of Legal Process	Executive Director, New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
	Legal process may also be served on the Plan Administrator, the individual Trustees, any insurer of benefits, or, with regard to any such insurer, the supervisory official of the local state insurance department.

Other Administrative and Funding Information

This section provides important information about third parties involved in providing and administering plan benefits. You may want to refer to this section for information if a question arises concerning a particular benefit.

Prescription drug benefits. Benefits under this program are paid out of Fund assets. The Fund has contracted with Caremark to administer the program on its behalf. In addition to forwarding to Caremark amounts required to pay plan benefits, the Fund also pays Caremark an administrative fee. Caremark can be reached at:

Caremark
2211 Sander Road
Northbrook, IL 60062
800-378-0972
www.caremark.com

Dental benefits. Benefits under this plan are paid out of Fund assets. The Fund has contracted with S.I.D.S. to provide claims and other administrative services. The Fund pays S.I.D.S. a fee for these administrative services, in addition to forwarding to it the amounts required to pay plan benefits. S.I.D.S. can be contacted at the following address:

Self Insured Dental Services
P.O. Box 9007, Dept. 95
Lynbrook, NY 11563-9007
516-396-5500, 718-204-7172
or toll-free 800-537-1238
www.asonet.com

Vision benefits and hearing aid benefit. Benefits under this plan are paid out of Fund assets. The Fund has contracted with General Vision Services (GVS), Comprehensive Professional Systems (CPS) and Vision Screening provide access to participating providers, process claims and other administrative services. (Vision Screening provides only vision services.) The Fund pays GVS, CPS and Vision Screening a negotiated fee. GVS can be reached at the following address:

General Vision Services
330 West 42nd Street
New York, NY 10036
212-594-2580

CPS can be reached at the following address:

Comprehensive Professional Systems, Inc.
48 West 21st Street
New York, NY 10010
212-675-5745

Vision Screening can be reached at the following address:

Vision Screening
1919 Middle Country Road
Centereach, NY 11720
631-467-4515

Life insurance. Benefits under this plan are insured by ULLICO. The Fund pays premiums to ULLICO for the coverage and ULLICO assumes responsibility for the payment of benefits. ULLICO can be contacted at:

ULLICO
111 Massachusetts Ave, N.W.
Mail Stop 709
Washington, DC 20001
866-795-0680

Short-term disability benefits. Benefits under this plan are paid out of Fund assets and administered through the Fund Office.

Scholarship program. Scholarship benefits are paid out of Fund assets and administered through the Fund Office.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the New York City District Council of Carpenters Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund office and at other specified locations, such as work locations and union halls, all documents governing the plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a "qualifying event." You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Receive a certificate of creditable coverage, free of charge, from your group health plan 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date your new group health plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning 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.

Assistance With Your Questions

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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 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 (formerly the Pension and Welfare Benefits Administration).

MEMBERS OF THE JOINT BOARD OF TRUSTEES

Trustees Designated by District Council	Title	Address
Michael J. Forde 212-366-7500	Chairman of the Board of Trustees New York City District Council of Carpenters	395 Hudson St. New York, NY 10014
Peter Thomassen 212-366-7500	Trustee New York City District Council of Carpenters	395 Hudson St. New York, NY 10014
Denis Sheil 212-366-7500	Trustee New York City District Council of Carpenters	395 Hudson St. New York, NY 10014
Vincent Alongi 212-366-7500	Trustee New York City District Council of Carpenters	89-07 Atlantic Ave. Woodhaven, NY 11421
Lawrence D'Errico 212-685-9567	Trustee New York City District Council of Carpenters	157 E. 25th St. New York, NY 10010
John Greaney 212-643-1070	Trustee New York City District Council of Carpenters	505 8th Ave., 4th fl. New York, NY 10018

Trustees Designated by Employers and Employer Organizations	Employer Association	Address
Joseph Olivieri 516-478-5600	Co-Chairman of the Board of Trustees Association of Wall-Ceiling and Carpentry Industries	125 Jericho Turnpike Suite 301 Jericho, NY 11753
George Greco 732-727-3020	Manufacturing Woodworkers Association of Greater New York, Inc.	Midhattan Woodworking Corp. Bordentown Avenue & Cheesequake Road Old Bridge, NJ 08857
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inside back cover