NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND

SUMMARY PLAN DESCRIPTION/ PLAN DOCUMENT

Effective July 1, 2019

TO ALL PLAN PARTICIPANTS:

This Summary Plan Description/Plan Document (together called the "Summary") has been prepared to provide you with details of the Plan available through the North Central States Regional Council of Carpenters' Health Fund for Construction Carpenters, Millwrights, Non-Bargaining Unit Employees, and Industrial Employees effective July 1, 2019. This Summary is both the Plan's Summary Plan Description and Plan Document. It describes the coverages available, how you qualify for them, and under what circumstances you may not be eligible. It also tells you how to file a claim for benefits and what action you can take if you are denied benefits.

Benefits under the North Central States Regional Council of Carpenters' Health Fund (Health Fund or Fund) are not vested or guaranteed. If there should be any conflicts or inconsistencies between this Summary and the actual provisions of the Trust Agreement, the Trust language will govern.

Only the Board of Trustees has the authority and reserves the right to amend, modify, or delete benefits, self-payment rates, or Eligibility Rules; to answer questions about eligibility and benefits; to interpret the Plan or any other provisions relating to the operations of the Fund; or to discontinue all or part of the Plan whenever, in their sole discretion, conditions so warrant. The Board has delegated some authority to the Fund Office staff in this regard. No Union or management representative, individual Trustee, or other individual has the authority to answer questions or to make decisions concerning the provisions of the Health Fund, unless such individual has been given the authority by Trustees and is acting on their behalf.

Any questions concerning eligibility, benefits, or any other matters relating to the Fund should be directed to the Fund Office. The address and telephone number is provided at the end of this letter.

The Eligibility Rules and benefits are maintained at levels in line with Trust Fund income and assets; they are reviewed regularly to provide the best protection possible within the Fund's financial means. Benefits payable are limited to Fund assets available for such purposes, regardless of accumulated eligibility. All Plan provisions are updated regularly to comply with current applicable federal laws, including the Patient Protection and Affordable Care Act.

Please read this entire Summary carefully so that you will know the benefits to which you and your family are entitled. Pay special attention to the Preauthorization and Precertification requirements described on pages xviii through xx to qualify for maximum benefits. Also, take advantage of the Preferred Providers described on pages 49 through 55 which offer you reduced rates on covered services and supplies.

From time to time, you will receive written notices of changes to the Plan. In order to be aware of changes to the Plan that may affect you or your Dependent's benefits, you must read these Participant Notices and file them with this Summary for reference.

We suggest you put this Summary in a safe place along with your other valuable papers so you have easy access to it when the need arises. If you have any questions at any time regarding the Plan, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES

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Chris Hill	Bob Barker
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NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY SERVICES

The North Central States Regional Council of Carpenters' Health Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Fund provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats) as well as language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. If you need these services, please contact the Fund Office.

If you believe the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-424-3405.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-424-3405.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-424-3405.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

Rufnummer: 1-800-424-3405.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-424-3405.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-424-3405.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-424-3405 번으로 전화해 주십시오.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-424-3405.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-424-3405.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-424-3405.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-424-3405.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-424-3405.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-424-3405 पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-424-3405.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-424-3405.

SCHEDULE OF BENEFITS

Classes C and O For Active Employees and Dependents		
COMPREHENSIVE MAJOR MEDICAL BENEFITS		
	PPO/POS Network Provider	**Non-PPO/POS Network Provider**
Deductible Amount[1,2,3] Per Eligible Person per Calendar Year Per family per Calendar Year	 $200 $600	 $ 400 $1,200
Plan's Copayment of Covered Charges[3,4]	90%	70%
Out-of-Pocket Maximum for Covered Charges per Calendar Year, including amounts applied to the deductible; copayment amounts, 10% copayment for one exam every two Calendar Years for pediatric vision for those under age 19; copayment for pediatric vision hardware; and the separate emergency room visit copayment.[2,3,4] Plan pays 100% of covered charges in excess of such maximum for such Eligible Persons for remainder of that Calendar Year, unless otherwise specified.	$1,500 per Eligible Person or $4,500 per family	$2,500 per Eligible Person or $7,500 per family
Comprehensive Major Medical Benefits cover expenses related to Hospital services, Physicians' services, x-ray and laboratory services, prescribed drugs and medicines (excluding those covered through PPRx), and other covered items and services when Medically Necessary. Amounts in excess of all maximums are the liability of the Eligible Person.		

[1] The deductible amount will be waived for the alternative ways of obtaining care and preventive care (see pages 37 through 40).

[2] Amounts satisfied at a network provider will be applied to the amount required at a non-network provider and amounts satisfied at a non-network provider will be applied to the amount required at a network provider.

[3] All emergency services rendered in an emergency department of a Hospital will be payable at the in-network level of benefits even if services are obtained at an out-of-network provider. Out-of-network emergency medical transportation also is payable at the in-network level.

[4] The Plan's copayment is reduced by 5%, up to a separate out-of-pocket maximum penalty for you of $500 for each non-emergency Hospital confinement which is not precertified as required. The amount resulting from such reduction in copayment will not be applied to deductible or previously stated out-of-pocket maximum requirements. Also see page xviii for a listing of certain procedures and treatments for which Preauthorization is recommended or Plan benefits will be denied if determined not to be medically necessary.

Classes C and O
For Active Employees and Dependents

COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)

Preventive care:[1]
Services from a Preferred Provider (as listed on pages 36 and 37) payable at 100% of Reasonable Expenses, no deductible, no Calendar Year maximum.
Out-of-network services (or in-network services not specified in listing on pages 36 and 37) payable as follows --

Routine physical examinations, 100% of Reasonable Expenses up to aggregate maximum of $531 for each Employee or Spouse per Calendar Year. Routine physical exam charges in excess of the $531 maximum are payable at 20%. Your copayment is not applied to out-of-pocket maximum.

Well child care, 100% of Reasonable Expenses for: routine examinations and laboratory tests recommended by the American Academy of Pediatrics from birth to age two; and up to $200 per Eligible Person per Calendar Year for Dependent children ages two and over. Well child care charges in excess of the $200 maximum are payable at 20%. Your copayment is not applied to out-of-pocket maximum.

Routine colonoscopy and electrocardiograms (EKG), 90% of Reasonable Expenses, no deductible, no Calendar Year maximum.

Cologuard (for routine colorectal cancer screening), covered at the applicable in-network or out-of-network copayment rate and subject to the applicable deductible and out-of-pocket maximum.

Routine immunizations (limited to those specified on page 36), 100% of Reasonable Expenses.

The deductible and copayment amounts are waived for covered charges related to the following alternative ways of obtaining care. The Plan pays 100% of the Reasonable Expenses incurred for such covered charges:

1. Hospice Care (Preauthorization recommended for home hospice and Precertification required for hospice care in a Hospice Facility).

2. Home Health Care (Preauthorization recommended).

3. Skilled Nursing Facility Care: up to 30 days of confinement per Injury or Sickness (Precertification required).

[1] If the Plan does not have an in-network provider who can provide a particular covered preventive service, then it will cover the item or service without cost-sharing when performed by an out-of-network provider acting within the scope of his/her license or certification.

Classes C and O For Active Employees and Dependents	
COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)	
Internal Limits Within Comprehensive Major Medical Benefits Certain services and supplies covered under Comprehensive Major Medical Benefits have their own limits and maximums in addition to being subject to the Comprehensive Major Medical Benefits deductible, copayment, and out-of-pocket maximum. Some of these limits are specified in this Schedule of Benefits and others are located within the text of the benefit description.	
Emergency room charges	Separate $150 copayment for each Hospital emergency room visit (waived when admitted to Hospital as inpatient or for observation)
Outpatient chiropractic visits for treatment of musculoskeletal and neuromusculoskeletal conditions	$40 maximum per visit (amounts in excess of such maximum are NOT included in the out-of-pocket maximum), up to 26 visits per Eligible Person per Calendar Year
Acupuncture services	$500 maximum per Eligible Person per Calendar Year
Infertility testing	Lifetime maximum of $4,000 per each Employee and Dependent Spouse **NOTE: Treatment of infertility is not covered.**
Vision therapy	$4,000 Lifetime maximum per Eligible Person
Temporomandibular joint disease (TMJ) treatment, including diagnostic tests and therapy but not surgery	$1,000 maximum per Eligible Person per Calendar Year
Morbid obesity treatment, including Physicians' services, lab work, and patient education in a medical setting	$500 Lifetime maximum per Eligible Person
Non-prescription drugs upon a Physician's written prescription (excluding those OTC drugs covered under the PPRx as specified on page x)	$50 maximum per Eligible Person per Calendar Year
Wigs and toupees for hair loss due to disease or medical treatment	$300 Lifetime maximum per Eligible Person

Classes C and O For Active Employees and Dependents	
COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)	
Hearing aids	Maximum one per ear every three Calendar Years up to $2,000 per aid
Hearing exams	One exam every three years
Experimental medical treatment and procedures (Preauthorization recommended), except routine costs associated with approved clinical trials as mandated by the Affordable Care Act	$5,000 aggregate maximum per Injury or Sickness
CPAP, BiPAP, and AutoPAP supplies (Preauthorization recommended)	$200 maximum per Eligible Person per Calendar Year
Genetic testing (Preauthorization recommended)	$1,500 Lifetime maximum per Eligible Person (unless otherwise required under Affordable Care Act as preventive care)
Organ Transplants	
Benefits self-funded by North Central States Regional Council of Carpenters' Health Fund[1]:	
Covered services for Hospital, surgical, and medical expenses and for postoperative immunosuppressant drug therapy	Payable under the Plan the same as for any other Injury or Sickness
Donor-related services maximum	$25,000

[1] Self-funded organ transplants apply only to cornea transplants and certain specified transplants for Medicare-Eligible Persons. All other transplants are insured according to the insurance policy described in the Organ & Tissue Transplant Certificate referenced in Appendix B.

Classes C, G, O, P, S, and T For Active and Optional Retiree Classes	
VISION CARE BENEFITS	
Plan's copayment	90%
Aggregate maximum per Eligible Person each two consecutive Calendar Years (current two-year benefit period is 2018-2019)[1]	$400
Please Note: Trustees have a Preferred Provider Agreement in effect with ShopKo Optical for covered eyewear and contact lens purchases (but excluding eye examinations). See page 53.	

DENTAL CARE BENEFITS	Delta Dental		CarePlus Dental[2]
	PPO	Premier and Out-of-Network	
Deductible Amount per Eligible Person per Calendar Year	$25	$25	$0
Plan's Coinsurance			
Diagnostic and Preventive Services	90%	90%	100%[3]
Basic and Major Services	90%	90%	80%[3]
Calendar Year Maximum per Eligible Person for diagnostic, preventive, basic, and major services	$1,200[4]	$1,200[4]	$2,000[5]
Routine Orthodontic Services[6]			
Deductible Amount	$0	$0	$0
Plan's Coinsurance	100%[7]	100%	50%
Orthodontia Lifetime Maximum per Eligible Person	$2,000	$2,000	$3,000

[1] For Eligible Persons under age 19; one vision exam every two Calendar Years will not be subject to the aggregate maximum; and Vision Care Benefits in excess of the $400 aggregate maximum will be payable at 10%.

[2] There is no coverage for out-of-network services under the CarePlus Dental benefit.

[3] No deductible applies.

[4] For Eligible Persons under age 19, diagnostic and preventive, basic and major dental services are subject to the deductible and coinsurance, but are not subject to the Calendar Year maximum.

[5] Cleanings and exams are not subject to the Calendar Year maximum.

[6] Orthodontics is not covered for Eligible Persons age 19 and older under the CarePlus Dental benefit.

[7] For Eligible Persons under age 19, Medically Necessary orthodontic services that are pre-approved by Delta Dental are covered at 90% coinsurance with no deductible or lifetime maximum.

Classes C, E, G, O, P, R, S, T, U, and V For Active and Retiree Classes	
PREFERRED PROVIDER PHARMACY PROGRAM	
Retail	
Eligible Person's copayment per covered prescription for up to a 30-day supply:	
Generic	$8.00
Brand name (including multi-source brand name contraceptives)	The greater of $15.00 or 25% of the cost, to a maximum of $35.00 per prescription
ACA Preventive Care drugs, with Physician's written prescription	$0.00
Smart-90 Retail Network	
Eligible Person's copayment per covered prescription for up to 90-day supply	
Generic maintenance drugs	$16.00
Brand name maintenance drugs	The greater of $30.00 or 25% of the cost, to a maximum of $70.00 per prescription
Mail-Service	
Eligible Person's copayment per covered prescription for up to 90-day supply	
Generic	$16.00
Brand name (including multi-source brand name contraceptives)	The greater of $30.00 or 25% of the cost, to a maximum of $70.00 per prescription
ACA Preventive Care drugs, with Physician's written prescription	$0.00
Specialty Medications (through Specialty Pharmacy)	
Eligible Person's copayment per prescription for up to a 30-day supply	25% of the cost, to a maximum of $50.00 per prescription
Out-of-Pocket PPRx Maximum per Calendar Year	
Per Eligible Person	$5,350
Per family	$9,200

Classes C and O For Active Employees Only	
DEATH BENEFITS	
Amount of Death Benefit	$20,000
Principal Sum for Accidental Death and Dismemberment	$20,000
ACCIDENT AND SICKNESS WEEKLY BENEFITS	
Weekly benefit rate	$350
Maximum number of weeks payable per disability	26
Accident and Sickness Weekly Benefits are limited to 10 days per Eligible Employee per Calendar Year for treatment of nervous and mental disorders while Hospital-confined and 30 days per each Eligible Employee's Lifetime for treatment of alcoholism and substance abuse while Hospital-confined. Benefits begin on the first day of a disability caused by an Injury and on the eighth day of a disability caused by a Sickness. An $800 per week pregnancy and post-delivery Accident and Sickness Weekly Benefit is available for mothers who are disabled while pregnant and/or following delivery of a child for a maximum of 26 weeks. The pregnancy and post-delivery Accident and Sickness Weekly Benefit is available during pregnancy for a pregnancy-related condition resulting in disability. Following childbirth, up to six weeks of post-delivery benefits are payable under the pregnancy and post-delivery Accident and Sickness Weekly Benefit (up to eight weeks for Cesarean delivery), subject to limitations noted on page 58.	

SCHEDULE OF BENEFITS

For Retired Employees and Dependents and Surviving Spouses	
The benefit provisions and amounts for Classes P, R, S, T, U, and V are identical to Class C, with the following exceptions:	
COMPREHENSIVE MAJOR MEDICAL BENEFITS Organ Transplants	 All Medicare-approved transplants are self-funded for Medicare-Eligible Persons in Classes S, T, U, and V, subject to the self-funded provisions on page 34.
VISION CARE BENEFITS	Classes P, S, and T only[1]
DENTAL CARE BENEFITS	Classes P, S, and T only[1]
DEATH BENEFITS (Employees Only) Amount of Death Benefit Principal Sum for Accidental Death and Dismemberment	 $4,000 $4,000
ACCIDENT AND SICKNESS WEEKLY BENEFITS	No Coverage

[1] **Please Note:** At the time of retirement, you have a one-time option to elect vision and dental coverage at an additional cost. This coverage is provided under Classes P, S, and T.

SCHEDULE OF BENEFITS

For Employees and Dependents Continuing COBRA Coverage	
The benefit provisions and amounts for Classes E and G are identical to Class C, with the following exceptions:	
VISION CARE BENEFITS	Class G only[1]
DENTAL CARE BENEFITS	Class G only[1]
DEATH BENEFITS	No Coverage
ACCIDENT AND SICKNESS WEEKLY BENEFITS	No Coverage

[1] **Please Note:** At the time of election, a COBRA Qualified Beneficiary has a one-time option to elect vision and dental coverage at an additional cost. This coverage is provided under Class G.

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PREAUTHORIZATION AND PRECERTIFICATION REQUIREMENTS[1]

FOR ALL CLASSES OF ELIGIBLE PERSONS

PREAUTHORIZATION

Preauthorization is a valuable tool to allow early case management for certain procedures and treatments and to determine the medical necessity of new, sometimes overused technology.

It is highly recommended that you obtain Preauthorization by Case Management Specialists (CMS) for the following:

Home Services:

- Home hospice.
- Home health care, including skilled nursing, therapies, equipment, and supplies.

Outpatient Procedures:

- Non-routine circumcisions.
- Dental services (if done in Hospital with anesthesia and if older than age 6).
- Experimental and investigational procedures.
- Breast reduction.
- Breast augmentation.
- Prophylactic mastectomies.
- Abdominoplasty.
- Panniculectomy.
- Botox.
- All sinus and throat procedures, excluding tonsillectomies. This includes, but is not limited to, laser uvulectomy UVP, Uvulopalato-pharyngoplasty UPPP, rhinoplasty, and septoplasty.
- All varicose vein procedures, ablations, and radiofrequency ablations.

Therapies:

- Physical therapy and occupational therapy after the initial evaluation and eight sessions; biofeedback after the eighth visit.

Treatments:

- Experimental and investigational treatments.
- Specialty medications given in an office setting including, but not limited to, Orencia, Remicade, and iron infusions.

Transportation:

- Ambulance transport, **non-emergency** ground and air.

Diagnostics:

- Amniocentesis if under the age of 35.
- Genetic testing.
- Neuropsychological testing/assessments.
- Sleep studies if under the age of 35 and home sleep studies.
- MRIs (including breast MRIs) and CT scans of the brain.

Durable Medical Equipment (DME):

- CPAP, BiPAP, and AutoPAP.
- Oral appliances, excluding TMJ.
- Oxygen.
- Bili lights and bili blankets (non-Hospital).
- Spinal cord stimulator.
- TENS unit, garment type only.
- Wheelchairs.
- Any DME, rented or purchased, with a charge of $500 or more.
- Any DME, regardless of charge, with over a 30-day rental period.
- Repair of DME according to provisions on pages 33 and 34.

[1] Medical Necessity criteria is available upon request.

If you do not obtain Preauthorization for these services and supplies and it is determined that they are not Medically Necessary, Plan benefits will be denied.

PRECERTIFICATION

To be eligible for the maximum benefits provided by the Plan and to avoid a reduction in your benefits as specified in the Schedule of Benefits, any non-emergency Hospital confinement requires Precertification by Case Management Specialists (CMS), including the following:

Inpatient Admissions (non-emergency):

- All medical, including obstetrical deliveries.
- Inpatient treatment of nervous and mental disorders, alcoholism, and substance abuse.
- Skilled nursing facilities.
- Hospice care in a Hospice Facility.

You do not need to precertify an emergency inpatient admission, but you must notify the Fund Office within 48 hours of admission.

Observation Stays:

- All Hospital observation stays that are over 23 hours.

To precertify, you must take a few simple steps before obtaining the specified health care services.

First, you (or someone on your behalf such as your Physician or the Hospital) must contact CMS at 1-800-861-8744. You can call during regular office hours to speak with someone directly or leave a message after hours and your call will be returned. You must provide the following information:

1. name, address, and birthdate of the patient;

2. names, addresses, and telephone numbers of the Physician and Hospital;

3. reason for the Hospitalization or surgery;

4. planned admission date, if applicable; and

5. name and identification number of the Eligible Employee.

Once CMS has received this information, they will contact your Physician to discuss the Injury or Sickness and the proposed treatment plan.

After this contact, your Physician will establish the appropriate length of time if you will need to stay in the Hospital. This is done to ensure you receive the level of care Medically Necessary for the treatment of the Injury or Sickness involved. In some instances, it may be recommended that you receive a second opinion.

Following the initial phone contact, if you do enter the Hospital, a review of your Hospital stay will be maintained to make sure you are receiving quality, cost-effective care that conforms to the original treatment plan.

Refer to the Organ & Tissue Transplant Certificate referenced in Appendix B for precertification (referred to as preauthorization on the Certificate) requirements and contact information for organ transplants.

See page 35 for prior approval requirements for self-funded organ transplants.

ELIGIBILITY RULES

ELIGIBILITY FOR BARGAINING UNIT EMPLOYEES, NON-BARGAINING UNIT EMPLOYEES, AND ALUMNI (CLASS C)

If you are working for a Participating Employer or Employers within the jurisdiction of any participating Union, or within a classification covered in an approved participation agreement, you are eligible to receive benefits under the Plan after meeting the eligibility requirements starting with Rule I on page 2. Additional terms and conditions governing eligibility for specific benefits are described with those benefits. Sole proprietors, partners, LLC's, LLP's, and 100% owners are not eligible to participate in this Plan even though they may perform work covered by a labor contract.

Under these Eligibility Rules, credits for eligibility will be based on Employer contributions being received by Trustees. If you receive a letter from the Fund Office informing you that your Employer is not making required contributions, please contact your Employer immediately to request that contributions be remitted. If your Employer does not remit the contributions, you will be responsible to make a self-payment to maintain your eligibility.

ELIGIBILITY FOR BARGAINING UNIT AND NON-BARGAINING UNIT EMPLOYEES OF INDUSTRIAL EMPLOYERS SIGNATORY TO A COLLECTIVE BARGAINING AGREEMENT WITH A UNION (CLASS O)

These Rules apply to Industrial Employers who are obligated to make payments to the Fund under a collective bargaining agreement with a Union participating in the Fund. If such Industrial Employer wishes to cover its Non-Bargaining Unit Employees, it must enter into a participation agreement. Eligibility of such Employers' bargaining unit and Non-Bargaining Unit Employees will be in accordance with the terms of the participation agreement and subject to the following eligibility requirements.

If you are working full-time for the Employer on the effective date of the Employer's participation, you are eligible for coverage on the first day of the calendar month for which contributions are received by the Fund on your behalf. If you are hired by the Employer after the effective date of participation, you are eligible for coverage the first day of the calendar month following your date of hire. You remain eligible for coverage for as long as Employer payments are received on time on your behalf under the terms of the collective bargaining agreement and the participation agreement. Your Dependents are eligible for coverage under this Plan on the date they first satisfy the definition of Dependent.

Only the following sections of these Eligibility Rules apply to Class O:

- Rule III, Self-Payment Option 2: COBRA Continuation Coverage (which is the only self-payment option for Class O);
- Rule IX: Termination of Coverage;
- Rule X: Coverage for Employees and their Dependents When Employee Enters Service in the Uniformed Services;
- Rule XI: Coverage While on Family and Medical Leave;
- Rule XIII: Change of Eligibility Rules;

- Rule XV: Conformity With Internal Revenue Code; and
- Rule XVI: Special Enrollment Periods.

In addition, upon retirement, Class O Employees will be permitted to continue coverage under the Retiree Program by making self-payments, provided such Employees satisfy the eligibility requirements for such Program specified on pages 6 through 10.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPT-OUT AND OPT-IN

A Dependent enrolled in a high deductible health plan ("HDHP") may elect to temporarily opt out of all Plan coverage, including HRA reimbursement. The Dependent may re-enroll in Plan coverage upon loss of the HDHP coverage pursuant to Rule XVI and may reinstate HRA eligibility as of the January 1 immediately following reinstatement of Plan coverage.

RULE I. INITIAL ELIGIBILITY

Bargaining Unit Employees, Non-Bargaining Unit Employees, and Alumni

You and your Dependents become initially eligible on the first day of the second month following the month in which you have worked and are credited with 500 hours of contributions at the Prevailing Contribution Rate as shown in the following chart. Hours contributed at less than the Prevailing Contribution Rate will be prorated. Such contributions must be credited within 12 consecutive months.

500th Hour Worked During	Contributions Received During	Initial Eligibility Begins
January	February	March 1
February	March	April 1
March	April	May 1
April	May	June 1
May	June	July 1
June	July	August 1
July	August	September 1
August	September	October 1
September	October	November 1
October	November	December 1
November	December	January 1
December	January	February 1

Initial eligibility continues for three consecutive months. If your initial eligibility effective date is other than the first day of the first month of a Coverage Quarter, your eligibility will be continued for a part of the next Coverage Quarter.

After your initial three consecutive months of coverage, you will remain eligible for the next Coverage Quarter or remainder of the next Coverage Quarter, subject to Rule II, "Continuation of Eligibility."

RULE II. CONTINUATION OF ELIGIBILITY

Bargaining Unit Employees

If you initially became eligible on the first day of the first month of a Coverage Quarter, you will continue to be eligible during subsequent Coverage Quarters provided:

1. you are working for a Participating Employer and Employer contributions for at least 390 hours are received during each Contribution Quarter preceding the Coverage Quarter; OR

2. you are not working for a Participating Employer or you are credited with less than 390 hours in a Contribution Quarter, but you are available for full-time Covered Employment and Employer contributions for at least 1,560 hours are received during the four Contribution Quarters preceding the Coverage Quarter.

If you initially became eligible on the first day of the second or third month of a Coverage Quarter, you will continue to be eligible during the remainder of the subsequent Coverage Quarter, provided you are working for a Participating Employer and Employer contributions for at least 390 hours are received during the Contribution Quarter preceding the Coverage Quarter.

ELIGIBILITY PERIODS are divided into Work Quarters and the corresponding Contribution and Coverage Quarters as follows:

WORK QUARTER	CONTRIBUTION QUARTER	COVERAGE QUARTER
DEC / JAN / FEB	JAN / FEB / MAR	MAY / JUN / JUL
MAR / APR / MAY	APR / MAY / JUN	AUG / SEP / OCT
JUN / JUL / AUG	JUL / AUG / SEP	NOV / DEC / JAN
SEP / OCT / NOV	OCT / NOV / DEC	FEB / MAR / APR

Example: Hours you work in December, January, and February will be contributed on in the Quarter beginning in January, and will provide eligibility for the Coverage Quarter beginning May 1.

Failure to satisfy the minimum hours requirement stated in this Rule II will cause your eligibility to terminate unless you continue with self-payments under Rule III.

Non-Bargaining Unit Employees and Alumni

If you are a Non-Bargaining Unit Employee or Alumni, you will continue to be eligible for each month Employer contributions are credited as follows:

1. For corporate officers and salaried Employees, a minimum of 40 hours each week of the Calendar Year. Corporate officers who receive no compensation are not eligible to participate in the Plan.

2. For hourly Employees, on all hours paid, with a minimum of 40 hours for each week you work at least one hour. No contribution will be required if no hours are paid during a week.

A Non-Bargaining Unit Employee or Alumni will continue to be eligible for each month for which he is credited with 30 hours for each week of the month while he is receiving credit under Rule IV on page 16.

You will have access to your accumulated eligibility as described in this section and self-payment privileges when you cease employment.

RULE III. SELF-PAYMENT OPTIONS

If Employer contributions have not been received for you for the required number of hours of work to maintain eligibility, you may make self-payments to maintain your and your Dependents' eligibility with Self-Payment Option 1 and/or Self-Payment Option 2. Self-Payment Option 1 is the Fund's traditional self-payment provision and Self-Payment Option 2 is the COBRA continuation coverage provision required by law.

Self-Payment Option 1

Self-payments are required on a quarterly or monthly basis. If your required quarterly self-payment is less than $500, you must pay the full amount due for the quarter. Quarterly self-payments must be received at the Fund Office by the 25th of the month preceding the first month of the Coverage Quarter or postmarked by the U.S. Postal Service by the 15th of the month preceding the first month of the Coverage Quarter, if mailed. You may make monthly payments if the required quarterly self-payment is $500 or more. If you pay each month, your eligibility is continued on a month-to-month basis. Monthly self-payments must be received at the Fund Office by the 25th of the month preceding the month of coverage or postmarked by the U.S. Postal Service by the 15th of the month preceding the month of coverage, if mailed. *For example, payment must be postmarked by the U.S. Postal Service by October 15, if mailed, or received by the Fund Office on or before October 25 for coverage in November.*

When you make a self-payment under Self-Payment Option 1, the number of hours on which the self-payment is based will be credited as work hours for the purpose of determining future eligibility and also for determining retiree subsidies.

You may use Option 1 to continue eligibility under the following circumstances.

When Employed Less Than 390 Hours Per Quarter

You will be allowed to make self-payments to the Fund to continue full Class C coverage, provided you certify in writing that you are available for full-time Covered Employment in the Fund's jurisdiction. The self-payment amount is equal to the lesser of the difference between

hours credited to you by Employer contributions or self-payments for a Contribution Quarter and 390 hours or the difference between hours credited to you for the previous 12 months and 1,560 hours.

When Completely or Partially Unemployed in Fund's Jurisdiction

Self-payments for Class C benefits will be in an amount equal to the Prevailing Contribution Rate multiplied by 390 hours. Trustees may revise the self-payment rate from time to time.

When completely unemployed in the Fund's jurisdiction, your self-payments will be limited to six consecutive Coverage Quarters.

When Injured or Sick

If contributions from Employers are not sufficient to continue your eligibility because of Injury or Sickness, you will be allowed to make self-payments to continue eligibility, provided:

1. such Injury or Sickness prevents you from actively working at Covered Employment;

2. you are not eligible for benefits under any other group health care plan as an employee; and

3. the Injury or Sickness has not resulted in your Total and Permanent Disability.

Trustees may require a statement from your Physician as evidence that you are temporarily unable to work at Covered Employment due to the Injury or Sickness.

Your self-payments to the Fund must be in an amount equal to the difference between hours credited and 390 hours multiplied by the Prevailing Contribution Rate. Self-payments under these circumstances will be limited to six consecutive Coverage Quarters.

When an Employee Dies

When you die, your Dependents' eligibility for benefits will terminate as follows:

1. If you were an active Employee when you died: on the date your accumulated eligibility is exhausted; or

2. If you were a retired Employee when you died: on the last day of the month following your death, except as otherwise provided in this section, "When an Employee Dies."

After your accumulated eligibility has been exhausted, your eligible surviving Spouse will be permitted to continue coverage under the applicable retiree class of coverage for herself/himself and your eligible Dependents by making self-payments. If your surviving Spouse has access to other employer-sponsored group health plan coverage, and elects to

enroll in that coverage, he or she will have a **one-time** opportunity to waive coverage under the Plan. To waive coverage under the Plan, your surviving Spouse must sign a waiver form certifying his or her coverage under the other employer-sponsored group health plan and submit proof of such coverage.

Your surviving Spouse may reinstate coverage in the Plan upon loss of the other employer-sponsored group health plan coverage. To reinstate coverage, your surviving Spouse must submit a completed enrollment form to the Fund Office within 60 days following the loss of other employer-sponsored group health plan coverage and proof that he or she, and any eligible Dependents, if applicable, were continuously covered under employer-sponsored group health plan coverage. Your surviving Spouse's, and Dependents', coverage under the Plan will be reinstated on the first day of the month following the Fund Office's receipt of an enrollment form, proof of continuous coverage, and the applicable self-payment.

The privilege to obtain continued benefit coverage under this Plan by making self-payments will terminate on the day:

1. your surviving Spouse remarries;

2. your surviving Spouse and/or Dependent children enroll in benefit coverage from another group health care plan by reason of employment, unless your surviving Spouse has submitted a waiver form as previously described; or

3. your surviving Spouse and/or Dependent children establish residence outside of the United States.

If your surviving Spouse loses Plan eligibility by enrolling in another group health care plan but subsequently loses coverage under that other plan, your surviving Spouse will be offered a one-time opportunity to enroll in coverage under this Plan if your surviving Spouse has maintained continuous coverage.

When an Employee Retires or is Totally and Permanently Disabled

Please Note: Retiree benefits are not vested and are subject to change or discontinuation as determined by Trustees. Trustees retain the right in their sole discretion to modify or discontinue retiree eligibility rules, types and amount of benefits, terms and conditions under which benefits are payable, and self-payment rates.

You will be considered retired for Plan purposes when you receive a retirement or disability benefit from the North Central States Regional Council of Carpenters' Pension Fund or another construction industry pension fund. At that time, you may use your accumulated eligibility (banked hours). However, when you have used your banked hours, you no longer will be eligible to continue coverage under any of the active Employee programs.

Exception: If you work and are credited with 390 or more hours during any Work Quarter, and you and/or your Spouse are Medicare-eligible, the Medicare-Eligible Person(s) will receive Class C active Employee benefits for the corresponding Coverage Quarter. If in any subsequent Work Quarter you are credited with less than 390 hours, benefits for the Medicare-Eligible Person(s) for the corresponding Coverage Quarter will revert back to the Class under which you were covered just prior to reinstatement in Class C.

You will have a one-time opportunity when you retire to elect coverage under the Retiree Program. If you elect not to continue coverage in the Retiree Program at the time of your retirement, you will not be allowed to elect such coverage at a later date unless you qualify for the one-time waiver/reinstatement provision on page 10. Retiree coverage will become effective no later than the first day of the quarter for which the active self-payment (based on hours worked prior to retirement date) exceeds the Retiree Program self-payment, provided you have completed the proper application for such coverage.

If you or your Dependent opt to enroll in Medicare Prescription Drug Benefits, your Medicare Prescription Drug Plan will become the primary payer for your prescription drug benefits, unless you are covered under an Active Plan in which case the Fund remains the primary payer. The Fund will consider your prescription drug expenses for payment only after the expenses have been considered by your Medicare Prescription Drug Plan. In addition, it will be your responsibility to submit proof of what the Medicare Prescription Drug Plan paid (Explanation of Benefits) before the Fund considers any balance. ***If you or your Dependent opt to enroll in Medicare Prescription Drug Benefits and drop coverage under the Plan, such person will lose all Plan benefits (including death, health care, optional dental and vision, and prescription drug). You will not be eligible to reinstate in the Retiree Program at a later date unless you qualify for the one-time waiver/reinstatement provision on page 10.***

1. **Retiree Program Requirements**

   When you retire, you may continue coverage for either Health Care Benefits only or, at your option, Health Care, Vision Care, and Dental Care Benefits for yourself and your Dependents in the Retiree Program, provided you satisfy the following requirements.

   a. provide written proof of retirement from your pension fund, be receiving Social Security retirement benefits, or, for Non-Bargaining Unit or Alumni Employees, provide:

      (i) If an owner, documentation of the change of officers filed with the state or proof of sale of the company.

      (ii) If an officer, documentation of the change of officers filed with the state and a letter from the company verifying the change.

      (iii) If an office Employee who is not an owner or officer, a letter from the company verifying your retirement; and

   b. be eligible as an active Employee during the Coverage Quarter immediately preceding the effective date of coverage in the Retiree Program [however,

this requirement will be waived if you: became permanently partially disabled, as determined by Trustees, on or after January 1, 2001; retired on or after January 1, 2005; were credited with 35,000 or more hours of contributions from contributing Employer(s) at the time of retirement; and are unable to perform enough Covered Work due to such disability in order to be eligible in the Coverage Quarter immediately preceding retirement]; and

c. have contributions made on your behalf by a contributing Employer(s) in each of the five years immediately preceding retirement [however, this requirement will be waived if you have been credited with 20,000 or more hours of contributions from contributing Employer(s) at the time of your retirement]; and

d. make the self-payment no later than the 25th day of the month preceding the current Coverage Month at a rate to be determined by Trustees from time to time. Self-payments postmarked by the 15th day of the month preceding the current coverage month will be considered timely.

If you are unable to satisfy the requirement in the prior subparagraph 1.c. because the collective bargaining unit in which you are employed has not participated in the Fund for five years, eligibility for participation may be determined by Trustees in other ways than from Fund records, such as determining your relationship to the industry prior to the bargaining unit joining the Fund. Further, solely for the purpose of satisfying subparagraph 1.c., hours of employment with the Carpenters Industrial Council prior to its merger into the Union shall be credited for purposes of satisfying the 20,000-hour requirement.

2. **Retiree Program Reinstatement**

When you or your surviving Spouse fail to make the required self-payment when due, you lose eligibility. However, you may request reinstatement of eligibility to participate in the Retiree Program. Such request for reinstatement must be made within 90 days of the date your eligibility otherwise would terminate and include an explanation satisfactory to Trustees of why it was not reasonably possible for you to make the required self-payment when due.

When your or your surviving Spouse's request for reinstatement in the Retiree Program is made within 90 days of the date your coverage otherwise would terminate and such request is approved, the required self-payment will be accepted retroactive to the first day of the first month for which a self-payment was not made.

3. **Eligibility for Retiree Program Subsidized Self-Payments**

In order to qualify for a subsidy, you must be a member of a participating Union or pay a service fee to a carpenters' local Union. Persons retiring at age 55 or later with a minimum of 10 years of service under this Plan, having at least 10,000 hours, will be eligible for a subsidy if available. *Owners must submit proof of retirement before the subsidy will be granted.* Totally and Permanently Disabled Participants will be eligible for a subsidy regardless of age to the extent they qualified prior to their disability.

Retirees age 55 or over with a minimum of 10 years of service and:	Percentage of Subsidy	
	Medicare-Eligible	Non-Medicare-Eligible
10,000 hours	15%	5%
15,000 hours	20%	10%
20,000 hours	25%	15%
25,000 hours	30%	20%
30,000 hours	35%	25%
35,000 hours	40%	30%

The percentage of subsidy for persons who retired prior to November 1, 2000, will not increase or decrease by more than 5% from the percentage of subsidy in effect April 30, 2002, in recognition of prior Trustee action which provided a 35% subsidy for persons who retired prior to November 1, 1995, and further provided a five-year transition rule for persons who retired on or after November 1, 1995, but prior to November 1, 2000.

Subsidy rates will not increase after retirement because of your age or return to Covered Employment.

Surviving Spouses are eligible for the Retiree Program and the scheduled subsidy to the extent you satisfied the eligibility requirements. If you die either before or after retirement, your surviving Spouse retains the rights to your subsidized rate, so long as Trustees continue the practice.

Trustees will reevaluate subsidies from time to time to make sure they are in line with the Fund's best interests. Any adjustments in the percent of subsidy in the future will affect each percentage category.

If you are a non-Medicare-eligible retiree who works for wage or profit for any non-signatory Employer in the construction industry or performs Covered Work for wage or profit for any non-signatory Employer, including work in an industrial trade you learned through Covered Employment, your eligibility to make subsidized self-payments will cease as of the last day of the month in which you begin such employment. If, within 60 days of the date your eligibility for a subsidy ends, you submit proof that your non-covered employment is terminated, your eligibility for a subsidy will be reinstated on a one-time basis.

If you are a retired Employee who continues to work at such non-covered employment, you will be eligible to make nonsubsidized self-payments at a rate to be determined by Trustees from time to time. If you continuously make nonsubsidized self-payments under this provision, and you otherwise are eligible for a subsidy under these Eligibility Rules, you will once again be eligible for a subsidy when you are enrolled in Part A and Part B of Medicare.

4. **Eligibility for Retiree Program Nonsubsidized Self-Payments**

You may make **nonsubsidized** self-payments under the Retiree Program at a rate to be determined by Trustees from time to time if you:

a. Satisfy the Retiree Program requirements stated in paragraph 1., but who do not qualify for a subsidy.

b. Do not maintain membership in a participating Union or do not maintain continuous payment of a service fee to the Health Fund.

Retirees who choose not to continue coverage under the Self-Payment Option 1-Retiree Program may choose to continue coverage under Self-Payment Option 2-COBRA continuation coverage.

5. **Retiree Program Waiver/Reinstatement Provision**

Retirees will have a **one-time** option to waive Health Plan coverage. If you are eligible to continue, or you are currently continuing coverage under the Retiree Program, you may elect to waive or terminate eligibility for all Health Plan benefits if you are enrolled in another employer-sponsored group health plan. You and your Spouse, if applicable, must sign a waiver form certifying your coverage under another group health care plan and submit proof of such coverage. The waiver will be effective as of the first day of the month following receipt of the waiver form and proof of other coverage. However, if you have accumulated eligibility under the Active Plan, the waiver will take effect when your accumulated eligibility runs out.

You can reinstate coverage in the Plan only at the time you and your Spouse, if applicable, terminate or become ineligible for the other group health coverage. To be eligible for reinstatement, you must submit an enrollment form to the Fund Office within 60 days following termination of coverage under the other group health plan along with proof that you and all your eligible Dependents were continuously covered under another employer-sponsored group health care plan after waiver of coverage under this Health Plan. Coverage will be reinstated on the first day of the month following receipt of an enrollment form, proof of other coverage, and the applicable self-payment.

Your eligibility for a subsidy, if any, is frozen when the waiver takes effect. You will be eligible for the subsidy applicable to your years of service and hours credited prior to retirement based on the rules in effect on the date of reinstatement into the Retiree Program. The self-payment amount will be based on the applicable rate at that time.

Termination of Active Benefit Coverage and Self-Payment Option 1 Privileges

If you work for a nonsignatory Employer in the construction industry, all eligibility for benefit coverage for you and your Dependents will terminate effective the first day of the calendar month following notice to you from the Fund Administrative Manager (but not earlier than 20 days after the date of such notice). You will not be permitted to make self-payments under Self-Payment Option 1 as of such termination date. However, you will be permitted to

make self-payments under COBRA Self-Payment Option 2. These provisions do not apply to any claim incurred before you lose eligibility for benefit coverage under this paragraph.

The termination of benefits and privileges under this section does not occur when you perform Covered Work for a nonparticipating Employer in the construction industry upon referral by Wisconsin Job Service, unless you then are offered Covered Work by a contributing Employer and you refuse such work offer. In that case, the termination provisions will apply as of the date of your refusal.

If your eligibility for coverage was terminated under this section and you then return to Covered Work, you will become eligible for benefits effective the day you return provided you have sufficient accumulated hours remaining on the date you return to work for a contributing Employer. If the hours of contribution remaining to your credit are insufficient for benefit eligibility, you will have your and your Dependents' eligibility for benefits reinstated according to Rule VI, "Reinstatement of Eligibility."

Self-Payment Option 2 (COBRA)

The intent of Self-Payment Option 2 is to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. Any future IRS guidelines will be incorporated even if it conflicts with existing Plan provisions.

You or your Dependents who do not qualify for Self-Payment Option 1 may continue eligibility for: Health Care Benefits and HRA Program; or Health Care, Vision Care, and Dental Care Benefits and HRA Program, if you and/or your Dependent are Qualified Beneficiaries and subject to the following conditions.

Qualifying Events

“Qualifying Events” are certain events that cause you or your Dependent to lose eligibility under the Plan.

The following are Qualifying Events if you are an Employee eligible because of Employer contributions upon:

1. a reduction in hours of Covered Employment for any reason, including, but not limited to, disability, Sickness, retirement, strike, lockout, or layoff; or

2. voluntary or involuntary termination of Covered Employment for any reason (except gross misconduct on your part), including disability, Sickness, or retirement.

The following are Qualifying Events for your Dependents if they occur while you as an Employee are eligible because of Employer contributions:

1. termination or reduction of your employment for any reason (except gross misconduct on your part), including disability, Sickness, or retirement;

2. your death;

3. divorce or legal separation from you;

4. you first become entitled to Medicare (eligible for and enrolled in coverage under Part A, Part B, or both) after the date on which COBRA continuation is elected; or

5. a Dependent child ceases to meet the definition of Dependent.

The start of bankruptcy action of an Employer contributing on behalf of Class O Non-Bargaining Unit Employees is a Qualifying Event for such Employees if the bankruptcy results in loss of coverage. Further, continuation coverage is available to Qualified Beneficiaries whose coverage is substantially eliminated within one year before or after the bankruptcy proceeding commenced.

You or your Dependent becomes a Qualified Beneficiary for a specific period of time when a Qualifying Event occurs. A Dependent child who is born to or placed for adoption with you during your period of COBRA continuation coverage will be treated as a Qualified Beneficiary. As a Qualified Beneficiary, eligibility may be continued for certain benefits through COBRA self-payments under the following provisions.

Notifications and Due Dates

1. **Qualified Beneficiary's Responsibility to Notify Trustees of a Qualifying Event**

   When the Qualifying Event relates to your divorce or legal separation, or to a Dependent child ceasing to meet the definition of Dependent, the Qualified Beneficiary must notify the Fund Office within 60 days of the Qualifying Event so that the Fund Office may provide proper notices and explanations to a Qualified Beneficiary about continued eligibility. You must provide this notice to the Fund Office by telephone, facsimile, or in writing by mail. See page ii for the telephone numbers and address. The Fund Office will advise the Qualified Beneficiary if additional supporting documentation is required. Failure to notify the Fund Office within 60 days of the Qualifying Event causes a person to lose the opportunity to continue coverage.

2. **Employer’s Responsibility to Notify Trustees of a Qualifying Event**

   Based on monthly Employer reports, Trustees are aware of Qualifying Events such as loss of eligibility because of a reduction in your hours or your ceasing active work. Notices explaining the right to continue coverage will be furnished to you and your Dependents when such Qualifying Event occurs.

   Employers also are responsible for notifying the Trustees of your death. However, to receive information about your COBRA rights promptly, you or your Dependent should notify the Fund Office of any Qualifying Event.

3. **Trustees' Responsibility to Notify a Qualified Beneficiary of COBRA Rights**

   The Fund Office, not later than 30 days after receipt of notice of a Qualifying Event, will advise the Qualified Beneficiary of the coverages, options, costs, and duration of these COBRA self-payment privileges.

4. **Due Date for Qualified Beneficiary's Response**

   A Qualified Beneficiary has 60 days from the date of coverage termination or the receipt of the COBRA Continuation Coverage Notice of Termination and Election Form, whichever is later, to elect whether to continue coverage. The election should be communicated to the Fund Office in writing on an Election Form. You and your Dependent each has the right to make an individual election. However, covered Employees may elect to continue coverage on behalf of their Dependents. Failure to state the election to the Fund Office within 60 days terminates rights to continued coverage under this provision.

   If you initially reject COBRA, you may change your mind as long as you do so before the 60-day election period expires. However, your COBRA coverage will not become effective until you file your Election Form.

5. **Due Date for Initial COBRA Self-Payment**

   The required initial COBRA payment must be made to the Fund Office not later than 45 days following the election to continue coverage (which is the post-mark date, if mailed). Failure to do so will cause eligibility and coverage to terminate retroactively to the date of the Qualifying Event and will cause loss of all continuation coverage rights under the Plan. The amount of the first COBRA self-payment is for the time period beginning with the date of the Qualifying Event and extending through the month in which payment is made.

6. **Due Date for Subsequent COBRA Self-Payments**

   Subsequent monthly COBRA self-payments must be made to the Fund Office by the first day of the month for that month of coverage. The Plan allows a 30-day grace period for making COBRA self-payments. Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if a periodic payment is made later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. Any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated. Failure to make subsequent COBRA self-payments before the end of the grace period will cause coverage and eligibility to terminate at the end of the month for which a timely COBRA self-payment last was made and will cause loss of all rights to continuation coverage under the Plan.

Coverages and Options

If a Qualified Beneficiary elects to continue coverage, the following benefits are available:

1. Health Care Benefits only; or

2. Health Care Benefits plus Vision Care and Dental Care Benefits.

The coverage selected may not be changed. However, coverage may be added for a new Spouse or to add a new Dependent child as a Qualified Beneficiary upon such child's birth or placement for adoption with you during your period of COBRA continuation coverage.

The Plan is required to offer continued coverage which, as of the day before coverage terminated, is identical to similarly situated Employees or family members who have not experienced a Qualifying Event. If coverage under the Plan is modified for similarly situated Employees, the Qualified Beneficiary's coverage also will be modified.

A Qualified Beneficiary does not have to show insurability to choose continuation coverage.

Cost of Continuation Coverage

The COBRA self-payment amount will depend on whether you continue Health Care Benefits only or Health Care plus Vision Care and Dental Care Benefits. The cost is determined annually by Trustees. There is a separate cost for continued coverage from the 19th through the 29th month for those individuals eligible for such disability extension. The Fund Office initially will notify the Qualified Beneficiary of the COBRA self-payment amount and due dates.

Duration of Continuation Coverage

When eligibility is lost due to termination of employment (other than for gross misconduct) or due to reduction in hours, a Qualified Beneficiary may continue eligibility for up to 18 consecutive months from the date employment terminated or hours were reduced, less the number of months eligibility was continued with full self-payments under Self-Payment Option 1. This 18-month period may be extended to 36 months for your Dependents if a second Qualifying Event [e.g. your death, divorce or legal separation from you, your coverage by Medicare (under Part A, Part B, or both), or a Dependent child ceasing to meet the definition of Dependent under the Plan] occurs during the 18-month period. These events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. A Qualified Beneficiary must notify the Fund Office within 60 days after a second Qualifying Event occurs to extend continuation coverage and provide any supporting documentation the Fund may request. This provision does not apply in the case of a reduction in work hours followed by a termination of employment.

This 18-month period may be extended up to a total of 29 months for all Qualified Beneficiaries during the disability of you or your Dependent, provided:

1. the Social Security Administration (SSA) determines that any of the Qualified Beneficiaries are disabled under the Social Security Act either: at the time employment terminated or hours were reduced; or at any time within 60 days of such Qualifying Event and the disability lasts at least until the end of the 18-month period of continuation coverage; and

2. the Qualified Beneficiary notifies the Fund Office in writing within 60 days of the SSA determination and before the end of the first 18 months of continuation coverage and provides a copy of the Social Security Disability Determination to the Fund Office.

Each Qualified Beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the Qualified Beneficiary is determined by SSA to no longer be disabled, the Qualified Beneficiary must notify the Fund Office within 30 days after the SSA determination.

Failure to provide notice of a disability or second Qualifying Event may affect the right to extend the period of continuation coverage.

When eligibility is lost due to your death, divorce or legal separation from you, your first becoming entitled to Medicare benefits (eligible for and enrolled in coverage under Part A, Part B, or both) after the date on which COBRA continuation coverage is elected or a Dependent child ceasing to meet the definition of Dependent under the Plan, your Dependents may continue coverage for up to 36 months from the date of the Qualifying Event, less the number of months eligibility was continued with full self-payments under Self-Payment Option 1. When the Qualifying Event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than you lasts until 36 months after the date of Medicare entitlement.

Multiple Qualifying Events

A Spouse or Dependent child, as a Qualified Beneficiary, may experience more than one Qualifying Event. However, the combined continuation coverage period for all such Events may not exceed 36 consecutive months from the date of the original Qualifying Event. The second or later Qualifying Events, provided they occur within the continuation period provided as a result of the original Qualifying Event, entitle a Qualified Beneficiary to continue coverage for an additional period but not longer than 36 months from the date of the original Qualifying Event. *For example, where a widow, as a Qualified Beneficiary, continued coverage for herself and children for 20 months and a child loses Dependent status, that child may continue coverage independently for the remainder of the time the mother is entitled to continue coverage.* This rule does not apply in the case of a reduction in work hours followed by a termination of employment.

Termination of COBRA Self-Payment Provisions for Qualified Beneficiaries

COBRA self-payments no longer are accepted and continued eligibility under this provision terminates in behalf of all Qualified Beneficiaries (unless specifically stated otherwise) when:

1. The Plan no longer provides group health care coverage to any Eligible Employee.

2. The required notice of a Qualifying Event is not provided by the Qualified Beneficiary within the time limits stated on page 12.

3. The election for continuation is not made within 60 days following the date of coverage termination or the receipt of the COBRA Continuation Coverage Notice of Termination and Election Form, whichever is later.

4. The initial COBRA self-payment is not paid by the due date stated on page 13.

5. The subsequent COBRA self-payments are not paid timely as stated on page 13.

6. A Qualified Beneficiary first becomes covered, after electing COBRA continuation coverage, under another group health care plan.

7. The maximum continuation coverage period is reached.

8. A Qualified Beneficiary first becomes entitled to Medicare (eligible for and enrolled in coverage under Part A, Part B, or both) after such person's COBRA election date (although other family members not entitled to Medicare will continue to be eligible for COBRA continuation). However, if a Qualified Beneficiary becomes entitled to Medicare due to End Stage Renal Disease (ESRD), coverage under COBRA Self-Payment Option 2 will not terminate automatically because of eligibility for Medicare. In the case of ESRD, the Fund is the primary source of coverage for up to 30 months from the date of ESRD-based Medicare entitlement, provided the person is an active Eligible Employee or Dependent or is covered under the Fund with COBRA continuation coverage. In the event the Fund's liability as the primary source of coverage for ESRD ends before the COBRA continuation period expires, the Fund becomes secondary to Medicare for the balance of the continuation coverage for such person.

9. For a Qualified Beneficiary who was entitled to the additional 11 months continuation coverage based on a disability extension--eligibility for continuing the disability extension will terminate when there has been a final determination that the disability no longer exists.

Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud).

If you are a former Employee who continued (or who is continuing) coverage under COBRA Self-Payment Option 2 and you subsequently return to Covered Employment, you must satisfy the requirements for initial eligibility specified in Rule I on page 2 before your coverage under Class C becomes effective.

RULE IV. MAINTENANCE OF ELIGIBILITY OF EMPLOYEES RECEIVING DISABILITY BENEFITS (CLASS C ONLY)

If you are eligible for coverage under the Plan and you either:

1. receive Accident and Sickness Weekly Benefits from this Plan; or

2. provide evidence of entitlement to benefits under any Worker's Compensation or Occupational Disease Law;

you will be credited with 30 hours each week you are entitled to or are receiving such benefits, up to 480 hours per disability. This credit will begin with the first day of your disability.

RULE V. MAINTENANCE OF ELIGIBILITY FOR APPRENTICES
(CLASS C ONLY)

If you are an Employee indentured into an Apprenticeship Program under the North Central States Regional Council of Carpenters' Training Fund, you may receive credits for the hours you spend in the classroom for classes required by the applicable apprenticeship standards. These classroom credits are subject to the following rules:

1. You will receive one hour of classroom credit, maximum of eight hours per day, for each hour of actual classroom attendance for related school instruction required by the Apprenticeship Program and verified by the North Central States Regional Council of Carpenters' Training Fund. No classroom credits will be granted for any other time, including travel time to and from class.

2. Each hour of classroom credit will count as one hour toward satisfying the Fund's continuation of eligibility requirements.

3. Classroom credits are limited to a maximum of 160 hours in any Calendar Year and an aggregate maximum of 400 hours.

Please note that classroom credits do not count as work hours in determining your level of subsidy as a retiree.

RULE VI. REINSTATEMENT OF ELIGIBILITY

If you have had a break in eligibility of one or more months, your eligibility will be reinstated for a period of three months beginning on the later of:

1. the first day of the third month following the month in which you have worked and are credited with contributions for 450 hours in not more than 12 consecutive months since your hours were last used for eligibility or self-contribution; or

2. the first day of the month following at least a one-month break in eligibility.

If you do not satisfy the prior requirements, initial Eligibility Rules will apply.

RULE VII. EMPLOYMENT OUTSIDE OF THIS FUND'S JURISDICTION

An Employer may continue to contribute on behalf of Employees working outside the territorial jurisdiction of any Union that is party to the Trust Agreement, provided they have a special agreement to fund out-of-area hours to the Fund. However, the Employer must continue to be recognized as a signatory Employer by the Trustees.

RULE VIII. EFFECTIVE DATE OF COVERAGE

If you are eligible for coverage on the effective date of this Plan, you will become covered by the Plan on that date. If you become eligible after the effective date of this Plan, coverage will be effective on the date you meet the requirements of these Eligibility Rules.

RULE IX. TERMINATION OF COVERAGE

Employees

Your eligibility in the Plan will terminate on the earliest of the following dates:

1. the date the Plan is terminated;

2. the date you no longer are eligible according to the Eligibility Rules even if you fail to notify the Fund Office;

3. the last day of the month you cease to be within the classes of persons eligible for coverage under the Plan;

4. for Class O, the last day of the month for which your Employer has paid the required contribution;

5. the end of the period for which any self-payment was due but not paid; or

6. the last day of the month in which the retiree exhausts accumulated eligibility unless coverage is elected.

For Classes C and O, the eligibility for benefits of the Employer's Non-Bargaining Unit Employees and their Dependents will be terminated, and no benefit claims will be paid in their behalf, in the event the Employer becomes delinquent in the payment of Fund contributions for the Employer's Bargaining Unit Employees under the applicable collective bargaining agreement.

Dependents

Your Dependents' coverage terminates on the earliest of the following dates:

1. the date the Plan is terminated;

2. the date the Plan no longer covers Dependents;

3. the date you no longer are eligible according to the Eligibility Rules;

4. the end of the month your Dependent no longer meets the requirements for the Plan's definition of "Dependent" even if you or your Dependent fail to notify the Fund Office;

5. in the event you die while an active Employee, the date your eligibility is exhausted, based either on hours worked or self-payments, unless the Dependent chooses to continue Dependent coverage through self-payments (OR for Class O, the last day of the month in which your death occurs, and for which month the Employer has paid the required contribution);

6. in the event you die while a retired Employee, on the last day of the month following your death. Dependents of deceased retired Employees may continue coverage through self-payments as provided for in the section, "When an Employee Dies," on page 5 (Rule III); or

7. the end of the period for which any self-payment was due but not paid.

RULE X. COVERAGE FOR EMPLOYEES AND THEIR DEPENDENTS WHEN EMPLOYEE ENTERS SERVICE IN THE UNIFORMED SERVICES

References to accumulated eligibility do not apply to Class O.

1. Eligibility Status

   a. You or an appropriate officer must submit advance notice of service in the Uniformed Services to the Fund Office (unless circumstances of military necessity as determined by the Defense Department make it impossible or unreasonable to give such advance notice.)

   b. If you or an appropriate officer do not submit such notice, your accumulated eligibility (as described in Rule II on pages 3 and 4), if any, will be used until exhausted to further extend your eligibility and the eligibility of your Dependents. Your coverage will terminate on the date all accumulated eligibility has been exhausted, or for Class O, the last day of the month for which the required Employer contribution has been paid. If you subsequently submit notice in a reasonable time period, the use of your accumulated eligibility will cease.

   c. For military leaves of less than 31 days in duration and for which you, an appropriate officer, or an Employer submit the required notice and otherwise satisfy the reemployment requirements described as follows, coverage for you and your eligible Dependents will be continued as though you are actively at work for the duration of such leave.

   d. For military leaves of 31 or more days in duration and for which you, an appropriate officer, or an Employer submit the required notice, coverage for you and your eligible Dependents will cease and your eligibility status will be frozen as of the date you leave employment for the purposes of performing service with the Uniformed Services, unless you elect to continue coverage as described in the following subsection 2.

   e. Your eligibility will be reinstated on the date you return to work for a Participating Employer (or upon making yourself available for work if no such work is available) within the applicable time limits stated in subsection 3., provided you otherwise satisfy the reemployment requirements necessary to qualify for reemployment rights under USERRA (e.g., provide evidence of honorable discharge, cumulative service in the Uniformed Services of no longer than five years). If your accumulated eligibility has been exhausted, you will be allowed to make self-payments under Self-Payment

Option 1 to be immediately reinstated in the Plan until you earn sufficient accumulated eligibility to sustain Plan coverage.

2. Continuation of Coverage

If you fail to provide advance notice of your service in the Uniformed Services, your coverage will terminate on the date your accumulated eligibility has been exhausted and you will not be eligible to continue coverage under this section unless your failure to provide advance notice is excused. Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If Trustees determine that your failure to provide advance notice is excused, you may elect to continue coverage, in accordance with this subsection 2., retroactive to the date you left employment for the purpose of performing services with the Uniformed Services, provided that you elect such coverage and pay all amounts required for the continuation coverage.

a. When the Fund Office has been notified that you are entering service with the Uniformed Services, you will be given the option of continuing your same class of coverage under the Plan. Continuation coverage under this subsection 2. is very similar to the continuation coverage described under Self-Payment Option 2, COBRA continuation coverage. The rules for election of and payment for continuation coverage are the same as the COBRA election and payment rules, provided the COBRA rules do not conflict with USERRA. If you do not elect continuation coverage and do not submit payment for all amounts required to continue coverage within the applicable COBRA timeframe, you will lose your right to continue coverage under this section and such right will not be reinstated.

b. You will have the option of using accumulated eligibility, if available, to continue coverage. If you do not have accumulated eligibility available or you choose not to use such hours, you are required to make timely self-payments at the COBRA rate to be determined by Trustees from time to time to purchase such COBRA continuation coverage. If you elect to use your accumulated eligibility to pay for continuation coverage and you exhaust your accumulated eligibility prior to the end of the maximum coverage period described in the following paragraph e., you may make self-payments to continue coverage through the end of your maximum coverage period.

c. The COBRA continuation coverage rules apply to payment for continuation coverage under this subsection 2. provided that the COBRA payment rules do not conflict with USERRA. You must make all required self-payments within the COBRA timeframe described under Self-Payment Option 2 to continue coverage under this subsection 2. unless the COBRA payment rules conflict with USERRA.

d. You and your eligible Dependents may continue coverage for a period ending the earlier of:

: the date that the Plan no longer provides group health care coverage to any Employees;

: the day after the date you fail to elect continuation coverage as required by the COBRA continuation coverage election rules;

: the first day of the month for which a timely self-payment has not been received and your accumulated eligibility has been exhausted;

: 24 months from the first date of absence due to service in the Uniformed Services; or

: the day after the date you fail to apply for reemployment with a Participating Employer within the applicable time period allowed under the following subsection 3. or otherwise cease to have USERRA reemployment rights.

The right to freeze eligibility and make self-payments under this provision ceases when you provide notice that you do not intend to return to work for a Participating Employer after uniformed service.

3. Status Upon Return from Military Service

If you are eligible for benefits when you enter service in the Uniformed Services and you have sufficient accumulated eligibility or make timely self-payments to maintain coverage upon your return to work, you and your eligible Dependents again will be eligible for benefits on the date of your return to work for a Participating Employer within the following time periods, provided you satisfy the other reemployment requirements of USERRA:

a. For periods of service in the Uniformed Services of less than 31 days, you must report to the Employer not later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of uniformed service plus eight hours, after a period allowing for safe transportation from place of Uniformed Service to place of your residence.

b. For periods of service in the Uniformed Services of more than 30 days but less than 181 days, you must apply for reemployment not later than 14 days after Uniformed Service is completed.

c. For periods of service in the Uniformed Services of more than 180 days, you must apply for reemployment not later than 90 days after Uniformed Service is completed.

Such time periods may be extended up to two years for injuries or Sicknesses, as determined by the Secretary of Veteran Affairs, to have been incurred or aggravated during your service in the Uniformed Services. If you exhaust your

accumulated eligibility prior to your return from uniformed service and you do not have USERRA reemployment rights, you will be treated as a new Employee.

If you exhaust your accumulated eligibility prior to your return from uniformed service and you satisfy the USERRA reemployment requirements, you will be eligible for benefits on the date of your return to work within the required time periods, provided you make self-payments required to continue eligibility under Self-Payment Option 1. If you fail to make self-payments as required upon reinstatement in the Plan, your eligibility for coverage will terminate as of the last date of the period for which a timely payment was received and you then will be treated as a new Employee.

For Class O, in the event a service-related disability prevents you from resuming Covered Employment, you will be covered under the Plan according to COBRA continuation coverage provisions. If you are killed in action, your surviving Dependents will be permitted to continue coverage according to COBRA continuation coverage provisions.

These rules are intended to comply with the requirements of USERRA. The USERRA provisions will control in the event there are any inconsistencies between the Act and the Plan.

The Plan will provide continuation coverage and reinstatement rights to the extent required by USERRA. You also may have continuation coverage rights under COBRA. Although the COBRA and USERRA provisions are similar, COBRA continuation coverage and USERRA continuation coverage are not identical. As long as you remain eligible simultaneously for both COBRA and USERRA continuation coverage, you will receive the more generous benefit rights that apply under these statutes. COBRA and USERRA continuation periods will run concurrently.

RULE XI. COVERAGE WHILE ON FAMILY AND MEDICAL LEAVE

If you become eligible for leave according to the Family and Medical Leave Act of 1993 (FMLA), your coverage under the Plan may be continued for the number of weeks mandated by law, provided your Employer is subject to the FMLA, makes the required contributions to maintain your coverage under the Plan, and files the appropriate notification and certification forms with the Fund Office.

To be subject to the FMLA, an Employer must have at least 50 Employees within 75 miles of your worksite during 20 or more workweeks in the current or prior Calendar Year. You may be eligible for FMLA if you worked for the same Employer for at least one year and for 1,250 hours over the last 12 months.

If your leave is eligible under the FMLA, and you do not return to work after the leave, then for COBRA continuation coverage purposes under Rule III on pages 11 through 16, the date of the Qualifying Event will be the last day of your FMLA leave. This provision will apply whether or not you elect to continue coverage under the Plan during the leave.

For additional information regarding your rights under the Family and Medical Leave Act, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under “U.S. Government, Department of Labor.”

RULE XII. CONTRIBUTIONS FOR WORK PERFORMED OUTSIDE THE FUND’S JURISDICTION

If you perform work outside the geographic area of a labor agreement requiring Employer contributions to this Fund, the Fund may receive contributions either directly from your Employer through another written agreement, or from the health fund covering the geographic area in which the work is performed (“Out-of-Town Health Fund”) through one of the following two options:

1. If your Employer and the labor organization in the geographical area where the work is performed agree in writing, this Fund may receive contributions for such out-of-town work.

2. In the event that you perform work outside the geographic area of a labor agreement requiring Employer contributions, this Fund for an Employer that is required by another labor agreement requiring Employer contributions to an Out-of-Town Health Fund, you may have up to twelve months of such contributions transferred to this Fund, provided:

    a. the Out-of-Town Health Fund has a reciprocity arrangement with this Fund;
    b. this Fund is your Home Fund by virtue of your Local Union membership; and
    c. you timely complete a written request on a form provided by this Fund.

When the contribution rate required to be paid to an Out-of-Town Health Fund is different than the rate required to be paid to this Fund, the hours credited to your record as a result of such contributions will be prorated.

If options 1 or 2 do not apply regarding work performed outside the geographic area of this Fund, you may continue coverage under this Fund only by making the required self-payment contributions while working for a Participating Employer outside such area.

If you transfer to a local labor organization affiliated with the same international labor organization as a Local Union participating in this Fund, you may make self-payments to this Fund to continue your eligibility until you become, or would become, eligible for benefit coverage from the appropriate Out-of-Town Health Fund. However, in no event can these self-payments be accepted after the earlier of:

1. the date of becoming eligible for benefit coverage from the Out-of-Town Health Fund; or

2. 18 months from the date that self-payments commenced.

If you participate in an Out-of-Town Health Fund and perform work within the geographic area of a labor agreement requiring Employer contributions to this Fund, up to twelve months of contributions received by this Fund may be transferred to the Out-of-Town Health Fund, provided:

1. this Fund has a reciprocity arrangement with the Out-of-Town Health Fund;

2. this Fund is not your Home Fund by virtue of your Local Union membership;

3. this Fund has not paid benefits for such hours; and

4. you timely complete a written request on a form provided by the Out-of-Town Health Fund.

Such contribution transfers to an Out-of-Town Health Fund will continue until the request is revoked in writing or we are notified that you transferred your Local Union membership to a Local Union participating in this Fund.

In no event will you receive duplicate health benefits from more than one health fund at any time.

RULE XIII. CHANGE OF ELIGIBILITY RULES

Trustees, in their sole discretion, are empowered to change or amend the Eligibility Rules at any time.

RULE XIV. CONTRIBUTIONS FROM SELF-EMPLOYED

Contributions from self-employed persons will not be accepted.

RULE XV. CONFORMITY WITH INTERNAL REVENUE CODE

Any provisions of these Eligibility Rules held to be unlawful or held to be inconsistent with the requirements for tax-exempt status of this Fund under the Internal Revenue Code will be void.

RULE XVI. SPECIAL ENROLLMENT PERIODS

1. Special Enrollment Period for Medicaid and the State Children's Health Insurance Program

   If your Dependent waived coverage under the Plan in writing because your Dependent is covered under a Medicaid plan or state Children's Health Insurance Program (CHIP), and your Dependent lose such coverage as a result of loss of eligibility, you may request coverage under the Plan no later than 60 days after the date coverage terminates.

   If you or your Dependent become eligible for assistance under a Medicaid plan or state CHIP (including under any waiver or demonstration project conducted under or in relation to those plans), you may request coverage under the Plan no later than 60 days after the date you or your Dependent is determined to be eligible for assistance.

The effective date will be the first day of the month following receipt of a timely request for enrollment.

2. Special Enrollment Period for Other Coverage

   If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption or if your Dependent waived coverage under the Plan in writing because your Dependent had other coverage, and your Dependent lost eligibility for such coverage or Employer contributions toward such coverage are terminated; or lose eligibility because your Dependent's eligibility for COBRA expired; you may request enrollment under the Plan within 30 days of the date of the events previously described. The effective date of coverage generally is the first day of the month following the request for enrollment, except that the effective date of coverage will be the date of the marriage, birth, adoption, or placement for adoption for those events.

NOTE: In order to receive benefits under the Plan, you must give the Trustees any information that is needed to coordinate benefits and administer the Plan. Your or your Dependent's action or inaction regarding the release or exchange of information between this Plan and any insurance company, other organization, or person when such information is necessary to determine eligibility, coordination and payment of benefits may cause your eligibility to be suspended. Benefits will not be paid when you withhold consent for release or exchange of information.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

Active and Retiree Classes
Classes C, E, G, O, P, R, S, T, U, and V

When you or your Dependent require covered services or supplies due to an Injury or Sickness, benefits are payable as specified in the applicable Schedule of Benefits.

DEDUCTIBLE

The deductible is the amount of covered charges you must pay before benefit payments will begin. The deductible is stated in the Schedule of Benefits. The deductible amount will be waived for the alternative ways of obtaining care on pages 37 through 40 and preventive care on pages 36 and 37. The deductible applies only once in any Calendar Year. So that you will not have to satisfy a deductible late in one Calendar Year and soon again the following year, any expenses incurred and applied against the deductible in the last three months of a Calendar Year also may be applied toward satisfying the deductible in the next Calendar Year.

Normally, the deductible is applied separately to each Eligible Person in a family. But, if two or more eligible members of a family are injured in the same accident, only one deductible will be charged against all resulting covered charges, regardless of the number of family members injured. A combined deductible also will apply to related covered charges for such common accident incurred in subsequent Calendar Years when new deductible amounts otherwise would apply.

COPAYMENT

After satisfaction of the deductible amount, the Plan pays a percentage of Reasonable Expenses incurred for covered charges at the applicable copayment stated in the Schedule of Benefits. Generally, you must pay the remaining copayment and any charges in excess of the Reasonable Expenses. However, you are not responsible for any amounts that exceed the provider's negotiated charge if you use a Preferred Provider. Further, the copayment will be waived for the alternative ways of obtaining care on pages 37 through 40 and preventive care on pages 36 and 37.

OUT-OF-POCKET

Reasonable Expenses you pay for covered charges (including amounts applied to the deductible amount; copayment amount; 10% copayment for one exam every two Calendar Years for pediatric vision for those under age 19; copayment for pediatric vision hardware; and the separate emergency room visit copayment) accumulate to the out-of-pocket maximum. When your out-of-pocket expenses reach the maximum stated in the Schedule of Benefits in any one Calendar Year, the Plan will pay 100% of the balance of covered Reasonable Expenses that exceed the out-of-pocket maximum for such Eligible Person(s) for the remainder of that Calendar Year. The chiropractic visit maximums will continue to apply once you have satisfied the out-of-pocket maximum.

The following charges are not included in the out-of-pocket maximum:

- copayment reduction of 5% for each non-emergency Hospital confinement or inpatient surgical procedure which is not precertified as required;
- copayment for out-of-network preventive care in excess of maximum;
- amounts in excess of maximum for out-of-network chiropractic visits;
- premiums;
- balanced-billed charges; and
- health care this Plan does not cover.

COVERED CHARGES

Benefits are payable for Reasonable Expenses for the following Medically Necessary services and supplies for treatment of an Injury or Sickness. Refer to the Schedule of Benefits for copayment amounts and benefit maximums.

Hospital Services[1]. Benefits for Hospital services recommended by the attending Physician include Hospital charges for:

1. semi-private room and board expense and confinement in an Intensive Care Unit;
2. drugs, medicines, diagnostic x-rays and laboratory tests, and other Hospital miscellaneous services and supplies not included in the room charges, if used while confined in the Hospital as a resident patient;
3. outpatient services in connection with surgery or related charges; and
4. emergency room services and supplies for the treatment of Injury or Sickness. All emergency services in an emergency department of a Hospital are payable at the in-network level of benefits even if services are obtained at an out-of-network provider.

Hospital charges incurred as a result of dental services are payable the same as any other Injury or Sickness if documentation is provided that an underlying medical condition necessitates such services. Examples of an underlying medical condition include asthma or a cardiac condition. A patient's age (unless under age six) or fear is not considered an underlying medical condition. Preauthorization is recommended, except for Dependent children under age six (see page xviii).

Hospital charges for room and board and miscellaneous charges for a healthy newborn Dependent child are payable the same as any other Injury or Sickness during the period the mother of the child is Hospital-confined as the result of giving birth to the child. In no event will Hospital benefits exceed five days or continue after the child's mother no longer is

[1] See page 52 for the benefits payable at a Preferred Provider Hospital. See the Schedule of Benefits for the copayment reduction and out-of-pocket penalty assessment for hospitalizations that have not been precertified as specified on page v.

Hospital-confined as a result of giving birth to a healthy newborn. Benefits are payable for state-required laboratory tests for newborn Dependents. Such benefits are payable up to the amount charged by the State Lab of Hygiene.

The Plan will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a Hospital length of stay not in excess of these periods. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 or 96 hours, as applicable.

Call CMS prior to any non-emergency Hospital admission. The case manager will monitor your Hospital stay to ensure that your care is Medically Necessary and appropriately delivered within medically acceptable guidelines and to arrange for a timely discharge. See page xix for Precertification requirements.

Hospital charges for confinements related to treatment of nervous and mental disorders, alcoholism, and substance abuse (including court-ordered therapy and therapy or treatment resulting from legal intervention) are payable the same as any other Injury or Sickness, including the Precertification requirement.

Physicians' Services. Benefits for Physicians' services include charges for:

1. Surgery[1] by a Physician or surgeon (and active services as an assistant surgeon), including circumcision of a newborn male Dependent child or the repair of a dislocation or fracture, up to the Reasonable Expense fee allowance.

   In the event that multiple surgeries are performed during the same anesthesia period, payment will be based on the American Medical Association coding guidelines.

   Charges for surgical assistance by a Physician's assistant or nurse practitioner are payable at 10% of the surgeon's Reasonable Expense fee allowance. When a surgical procedure warrants the use of an assistant surgeon, charges are payable at 25% of the Reasonable Expense fee allowance.

   Reasonable Expenses incurred for non-dental-related oral surgery performed by a doctor of dental surgery (D.D.S.) are payable the same as any other surgical procedure, subject to the deductible and copayment requirements. Covered procedures include:

   a. surgical removal of impacted teeth;

   b. surgical procedure of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require pathological examination;

[1] See the Schedule of Benefits for the copayment reduction and out-of-pocket penalty assessment for certain non-emergency surgical procedures which have not been precertified as specified on page v. Also, it is recommended that certain procedures specified on page xviii be preauthorized or Plan benefits will be denied if they are determined not to be Medically Necessary.

c. surgical procedures required to correct injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

d. excision apex of the tooth root (apicoectomy);

e. excision of exostoses of the jaws and hard palate;

f. treatment of fractures of the facial bones;

g. external incision and drainage of cellulitis;

h. incision of accessory sinuses, salivary gland ducts;

i. surgical reduction of dislocation and excision of the temporomandibular joints;

j. surgical periodontic procedures - excision of loose gum tissue to eliminate infection;

k. leveling of structures supporting teeth for the purpose of fitting dentures (alveolectomy);

l. temporomandibular joint surgery on a case-by-case basis;

m. orthognathic surgery for malocclusion of teeth;

n. preprosthetic surgery, vestibuloplasty with and without skin graft or palatal graft;

o. preprosthetic surgery, hydroxyapatite buildup; and

p. tooth extraction and replacement of teeth (through dental implant or dental appliance, such as dentures), when arising from head and neck radiation and/or chemotherapy treatments.

Benefits are payable for one voluntary sterilization per Lifetime for the Employee and Dependent Spouse only, except as required by the ACA.

Surgical benefits are payable for elective termination of pregnancy for Employees and Dependent Spouses when the results of an amniocentesis indicate a fetal abnormality. Medical documentation verifying the test results will be required by the Fund Office.

For individuals receiving mastectomy-related benefits, coverage will be provided on the same basis as other medical and surgical procedures covered by the Plan and in a manner determined in consultation with the attending Physician and the patient for all stages of reconstruction of the breast and nipple of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses and surgical bras; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits are payable in addition to those payable for the mastectomy itself

and related Hospital costs. Benefits will be payable for the reconstructive surgery, whether performed immediately after a mastectomy or delayed to a later date.

Coverage will be provided for prophylactic mastectomies (and reconstruction of both breasts) provided certain criteria maintained by CMS are satisfied. Contact CMS for more details.

2. Anesthetic and its administration by a professional anesthetist or other legally qualified Physician acting within the scope of his or her license. The services of a Physician and certified registered nurse anesthetist jointly providing anesthesia service will be paid at 50% of the Plan's Reasonable Expense fee allowance for each provider, or if a Preferred Provider, at 50% of the total allowance under the PPO fee schedule.

3. Medical services rendered during in-Hospital, Hospital outpatient, office, or home visits.

   Services of a Chiropractor or other legally qualified Physician acting within the scope of his or her license, will include musculoskeletal and neuromusculoskeletal conditions. Coverage is provided for chiropractic care for Dependent children ages 6 to 12 for treatment of documented injuries only, unless a Physician provides written documentation establishing Medical Necessity. Coverage is excluded for chiropractic care for Dependent children ages 5 and under, unless a Physician provides written documentation establishing Medical Necessity.

   Coverage for acupuncture by a licensed acupuncturist or other legally qualified Physician acting within the scope of his or her license, will be subject to medical guidelines which specify certain conditions and diagnoses for which acupuncture is recognized to be effective, including but not limited to: postoperative or chemotherapy-related nausea or vomiting; nausea associated with pregnancy; fetal breech position; temporomandibular joint disorders (TMJ); and chronic pain for certain conditions such as migraine headaches, osteoarthritis of the knee or hip, and chronic low back pain.

   The services of a licensed psychiatrist (M.D.) or any other legally qualified Physician acting within the scope of his or her license are payable for the outpatient treatment of nervous and mental disorders, substance abuse, and alcoholism. Expenses related to services of a psychologist, therapist, or counselor for these three conditions are covered to the same extent as those of a Physician.

   Outpatient visits for the treatment of nervous and mental disorders, alcoholism and substance abuse (including court-ordered therapy and therapy or treatment resulting from legal intervention) are payable the same as any other Injury or Sickness. Coverage is provided for Physicians' services only for individual and group therapy. **Marriage/couple counseling and counseling for parenting are not covered expenses. Psychological testing is not a covered service for the treatment of a nervous or mental disorder**. Neuropsychological testing/assessments are covered; Preauthorization is recommended (see page xviii).

4. Services of a Physician related to your or your Spouse's routine physical (see page 36 for details).

5. Examination of a newborn Dependent child when the examination is performed within 48 hours of birth.

6. Services of Physician related to routine well child care (see page 36 for details).

7. Diagnostic tests, therapy, and treatment (exclusive of surgery which is covered the same as any other surgical procedure) related to temporomandibular joint disease (TMJ). Payment will be made whether the work is performed by a Physician (M.D.) or Doctor of Dental Surgery (D.D.S.).

8. Physicians' services, lab work, and patient education in a medical setting for the treatment of morbid obesity, provided required criteria maintained at the Fund Office are satisfied.

9. Sclero-therapy for treatment of varicose veins.

X-Ray and Laboratory Services. Benefits for diagnostic x-rays and laboratory tests when performed by or under the supervision of a Physician or Chiropractor and provided by a Medicare-certified laboratory.

Benefits are payable for state-required laboratory tests for newborn Dependents performed on an outpatient basis, provided such tests would have been covered if mother and child had remained Hospital-confined. Such benefits are payable up to the amount charged by the State Lab of Hygiene.

Random drug testing will be covered, provided such testing is a requirement of an outpatient substance abuse treatment program that is provided by a facility licensed to treat alcohol and substance abuse.

Benefits also are payable for infertility testing for Employees and Dependent Spouses. Coverage will not be provided for treatment of infertility, including prescription drugs, artificial insemination, gamete intra-fallopian transfer (GIFT), intrauterine and invitro-fertilization, perganol, and surgical intervention for the sole purpose of treating infertility.

Preauthorization is recommended for MRIs and CT scans of the brain (see page xviii).

Drugs and Medicines. Benefits for drugs and medicines covered under Comprehensive Major Medical Benefits include charges for:

1. Take-home prescription drugs purchased at the Hospital pharmacy at the time of discharge.

2. Prescription drug claims for which this Plan is the secondary payer and which have been processed by the primary carrier.

3. Non-prescription drugs and medicines, provided a Physician has recommended and made a written order for their use.

4. Drugs and medicines administered by a Physician. Preauthorization is recommended for specialty medications given in an office setting including, but not limited to, Orencia, Remicade, and iron infusions (see page xviii).

See the description of the Preferred Provider Pharmacy Program on pages 49 through 52 for benefits payable for all other prescription drugs and page 36 for coverage of routine immunizations.

Other Covered Charges. Benefits for the following services and supplies which are recommended by the attending Physician and not included in the covered charges described previously.

1. Other Hospital charges incurred as an outpatient.

2. Charges of--

   a. A qualified physical or occupational therapist to restore a function lost due to Injury or Sickness. Preauthorization is recommended after the initial evaluation and eight sessions (see page xviii).

   b. An appropriately trained professional for speech therapy or feeding therapy to restore a function lost due to Injury or Sickness.

   c. An appropriately trained Physician, such as an Optometrist, for vision therapy.

   d. A registered nurse or any other legally qualified Physician acting within the scope of his or her license for nursing service rendered solely for the Eligible Person, except for services provided by a person who ordinarily resides in the Eligible Person's household or is a member of the family.

   e. A nurse practitioner acting within the scope of such license.

   f. A nurse midwife for a normal delivery at a Hospital, payable at the same benefit level as when such services are performed by a Physician.

3. Charges for local professional ambulance service by professional ground or air ambulance, railroad, or commercial airline on a regularly scheduled flight. If the Injury or Sickness requires special and unique Hospital treatment, ambulance benefits will be payable for transportation within the United States or Canada to the nearest Hospital equipped to furnish the treatment not available in a local Hospital. Benefits are not payable for transportation or transfer based solely on your convenience, personal preference, or any reason other than Medical Necessity. Preauthorization is recommended for non-emergency ground and air ambulance transport (see page xviii).

4. Charges for the following additional services and supplies--

   a. Radiation therapy.

   b. Blood or blood plasma and its administration.

c. Testing of pacemakers.

d. Casts.

e. Initial artificial limbs and eyes to replace natural limbs and eyes within six months of the date of the loss.

f. Replacement of artificial limbs and eyes.

g. Initial contact or implanted lens if used to replace a lens removed because of a cataract.

h. Initial breast prosthesis for breast removed due to mastectomy within six months of the mastectomy and one replacement prosthesis for each breast every three Calendar Years.

i. Costs related to the removal and replacement of faulty breast implants that were initially implanted following a mastectomy.

j. Wigs and toupees when hair loss is the result of a disease or medical treatment.

k. Dental services rendered by a Physician or Dentist for treatment within 12 months of an Injury to the jaw or natural teeth, or when arising from head and neck radiation and/or chemotherapy treatment, within 12 months of completion of such treatment, including the initial replacement of these teeth and any necessary dental x-rays. Treatment may be extended past the initial 12-month treatment period for a period of up to five years following the date of Injury or head and neck radiation and/or chemotherapy treatment, provided a treatment plan from the treating Physician or Dentist is submitted to the Plan with substantiation that the corrective treatment could not be completed within the initial 12-month treatment period.

l. One hearing aid exam per Eligible Person once every three Calendar Years and one hearing aid per ear once every three Calendar Years when prescribed by a Physician. *Delta Dental offers a hearing aid discount program at network providers to maximize your benefit.*

m. Initial newborn Dependent child hearing exam when performed on an outpatient basis, provided such test would have been covered if mother and child had remained Hospital-confined.

5. Experimental medical treatment and procedures. Preauthorization is recommended (see page xviii).

6. Specified medical supplies and durable medical equipment as determined by Trustees from time to time and of which a written record is maintained by CMS. It is recommended that you obtain Preauthorization for certain supplies and equipment (see page xviii). The Plan will cover: CPAP, BiPAP, and AutoPAP replacement supplies; repair of covered durable medical equipment when the

damage is not due to abuse or neglect, the cost of repair is projected to be less than the cost of replacement, the equipment has been maintained according to the manufacturer's recommended maintenance schedule, and CMS has authorized the repair in advance; and replacement of covered durable medical equipment.

7. Genetic testing. Preauthorization is recommended (see page xviii).

8. Amniocentesis (for Employee and Dependent Spouse only) when there is a documented medical indication of a potential Injury or Sickness of the fetus or mother. Preauthorization is recommended if under the age of 35 (see page xviii).

9. The Cologuard colorectal cancer screening test when ordered by a Physician, payable subject to these Medicare guidelines. The Cologuard test will be covered once every three years for Eligible Persons who meet all the following criteria:

    a. age 50 to 85 years old;

    b. asymptomatic (no signs or symptoms of colorectal disease, including but limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and

    c. at average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Sleep Disorders. Benefits are payable for costs related to sleep studies conducted in a licensed sleep lab or for home sleep studies, provided certain conditions are satisfied. Written guidelines are maintained by CMS. Preauthorization is recommended for home sleep studies and if you are under age 35 (see page xviii).

Organ Transplants. Benefits for covered charges for cornea transplants and, for Medicare-Eligible Persons in Classes S, T, U, and V, Medicare-approved transplants of the following human organs or tissues when transplanted to an Eligible Person:

- bone marrow, except those resulting from T-cell leukemia
- liver
- heart
- heart/lung (single or double)
- lung (single or double)
- pancreas
- pancreas/kidney
- kidney
- small bowel

All other organ and tissue transplant coverage is provided under a separate insurance policy (described in the Organ & Tissue Transplant Certificate referenced in Appendix B). Such policy pays benefits for certain organ and tissue transplants without regard to any benefits that may be provided by the Plan. Refer to the Certificate for benefit information, preauthorization of transplant services, and transplant network provider access. Expenses billed by the transplant provider that are not covered by the Certificate are subject to the Plan's benefits and the payment terms and conditions of the transplant provider's contracted rates.

Benefits for cornea and Medicare-approved organ transplants are payable provided each of the following conditions is satisfied:

1. The Eligible Person receives two written opinions by board-certified specialists in the involved field of surgery on the necessity for transplant surgery.

2. The specialists certify in writing that alternative procedures, services, or courses of treatment would not be effective in the treatment of the Eligible Person's condition.

3. All decisions related to the transplant surgery satisfy applicable state requirements.

4. The Eligible Person must contact the Fund Office to initiate the organ transplant approval process. The Board of Trustees approves the transplant decision, based on the specialists' certification and may designate approved transplant facilities.

Covered charges include Reasonable Expenses incurred for the following services and supplies, provided the transplant recipient is an Eligible Person:

1. Donor-related services for self-funded transplants include: testing to identify suitable donor(s); life support of a donor pending removal of a usable organ(s); and human organ and tissue procurement including removing, preserving, and transporting the donated organ or tissue. Benefits for donor-related services also are payable to compensate an organ or tissue bank for the procurement, preservation, and transportation of an organ and are payable at the time of service. However, benefits are not payable for any financial consideration to a donor.

2. Postoperative followup expenses, including immunosuppressant drug therapy.

3. All covered services for the recipient will be payable under the Plan the same as for any other Injury or Sickness.

If an Eligible Person requires more than one covered transplant procedure, covered transplant services during each transplant benefit period are payable as follows. The transplant period consists of five days before and 18 months after the date of the transplant.

a. If each covered transplant procedure is due to unrelated causes, each covered transplant procedure will begin a separate transplant benefit period.

b. If each covered transplant procedure is due to related causes, each covered transplant procedure will begin a separate transplant benefit period if, in the case of an Eligible Employee, the transplant procedures are separated by the Eligible Employee’s return to being actively employed for 90 days, and in the case of a Dependent, the transplants are separated by at least 90 days.

c. If the covered transplant procedures are due to related causes, they are considered one transplant benefit period when not separated as stated and the covered transplant benefit period is determined in accordance with the earlier covered transplant procedure.

Benefits for replacement transplant(s) if the first organ fails are limited to 50% of the maximum amount otherwise payable.

Benefits are payable for the temporary use of mechanical equipment which is not Experimental pending the acquisition of "matched" human organ(s).

No organ transplant benefits are payable for:

1. services not ordered by a Physician;

2. any expenses for a transplant when approved alternative courses of treatment are available or when other specified conditions are not satisfied;

3. animal or mechanical organs for transplantation;

4. investigational drugs;

5. any items specified in the Plan's General Exclusions on pages 78 through 83 of this SPD;

6. purchase of the organ or tissue; or

7. the temporary use of Experimental mechanical equipment.

PREVENTIVE CARE

When Obtained at a Preferred Provider

The Plan will pay 100% of Reasonable Expenses with no deductible requirement and no Calendar Year maximum for the following preventive services from a Preferred Provider. Covered charges include:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). For Dependent children from birth to age two, the Plan covers routine examinations and laboratory tests recommended by the American Academy of Pediatrics.

4. With respect to women, evidence-informed preventive care and screening as provided for in the comprehensive guidelines supported by HRSA, with the following limitations:

a. contraception in each FDA-approved contraception method is covered under this preventive care benefit, except those methods covered under the PPRx.

b. Purchase of electric or manual breast pump is limited to one every five Calendar Years.

The list of recommended preventive health services is subject to change and may have varying effective dates for specific services. For information on whether a specific preventive service or immunization is covered at 100%, you can contact the Fund Office or visit the federal government's website at:

https://www.healthcare.gov/preventive-care-benefits/

The Plan may apply reasonable medical management techniques to determine coverage limitations, if any, in cases where the recommendations or guidelines for a recommended preventive service do not specify the frequency, method, treatment, or setting for the provision of that service.

The Plan also covers preventive services not specified on the prior list as stated in the Schedule of Benefits.

When Obtained at an Out-of-Network Provider

The Plan covers preventive services including routine physical examinations, well child care, routine colonscopy and electrocardiograms (EKG) obtained at an out-of-network provider as stated in the Schedule of Benefits. The Plan also covers the following routine immunizations:

1. For adults: tetanus, Hepatitis B, influenza, pneumonia, and shingles.

2. For Dependent children: immunizations required to attend public schools and influenza shots.

Limitations

The Plan does not cover the following services under this preventive care benefit:

1. Immunizations recommended or required for foreign travel.

2. Examinations for which benefits are provided under any other section of the Plan;

3. CT colonography (virtual colonoscopy); or

The Plan covers Cologuard for routine colorectal cancer screenings subject to the applicable copayment rate stated in the Schedule of Benefits.

ALTERNATIVE WAYS OF OBTAINING CARE

To encourage you and your Physician to use cost-effective services and facilities, the Plan waives the deductibles and copayments for the following benefits.

Hospice Care

Hospice care allows a terminally ill patient to receive appropriate care in the most comfortable, home-like atmosphere possible. When it is medically determined that an Eligible Person is terminally ill, the Eligible Person (or authorized representative, such as a family member) and the Physician may prefer to obtain hospice care as opposed to Hospital confinement. Benefits are payable for 100% of Reasonable Expenses for covered hospice services during the period in which the Eligible Person otherwise would have to be Hospital-confined, subject to rates established by Trustees from time to time. Benefits are payable for home care administered under an approved Hospice Program or Home Health Care Agency at the patient's home, or for care in a hospice unit of a Hospital or a separate Hospice Facility.

The following hospice care services are covered:

1. Physicians' visits;

2. care provided by registered nurses (R.N.) and home health care aides;

3. assessment visit by a Hospice Program staff member;

4. drugs and certain supplies prescribed by a Physician; and

5. respite care, up to five consecutive inpatient days at a time, only when necessary to provide occasional relief to family members or significant other individuals caring for the terminally ill Eligible Person in their own or the Eligible Person's residence.

In the event the medical determination is made that the terminal condition is reversed, benefits are payable as provided under other sections of the Plan.

Preauthorization is recommended for home hospice care expenses (see page xviii). Precertification is required for hospice care in a Hospice Facility (see page xix).

Home Health Care

Benefits are payable for 100% of Reasonable Expenses incurred by Eligible Persons for home health care services provided in the patient's home provided the attending Physician certifies that:

1. Hospitalization or confinement in a Skilled Nursing Facility would be required in the absence of home health care;

2. your family or persons residing with you cannot provide necessary care and treatment; and

3. home health care services are coordinated by a state-licensed or Medicare-certified Home Health Care Agency or certified rehabilitation agency.

Preauthorization is recommended for home health care expenses (see page xviii).

Home health care services include:

1. part-time or intermittent nursing care under the supervision of a registered nurse (R.N.);

2. physical, respiratory, occupational, or speech therapy;

3. medical supplies, drugs, and medications prescribed by a Physician and laboratory services to the extent they would have been covered during a Hospital confinement;

4. nutritional counseling by a registered dietician; and

5. evaluation of the need for development of a plan for home health care by an R.N., Physician extender, or medical social worker when requested or approved by the attending Physician.

Home health care benefits are NOT provided for:

1. food (including formula), housing, homemaker services, or home-delivered meals;

2. custodial care;

3. services or supplies not included in the home health care plan established for the patient;

4. services provided by the patient's family or anyone residing with the patient; or

5. any services not specifically listed in this section.

Skilled Nursing Facility Care

If you or your Dependent are confined in a Skilled Nursing Facility, benefits are payable for 100% of the Reasonable Expenses for up to 30 days of confinement per period of Injury or Sickness provided:

1. you are transferred to the Skilled Nursing Facility within 30 days of Hospital discharge;

2. you were Hospital-confined based on medical necessity immediately before transfer to the Skilled Nursing Facility;

3. Skilled Nursing Facility care is needed for care of the same condition treated in the Hospital;

4. the attending Physician certifies the medical need for daily skilled nursing or skilled rehabilitation services which, for all practical purposes, only can be provided in a Skilled Nursing Facility;

5. the patient receives Medically Necessary skilled nursing or skilled rehabilitation services on a daily basis; and

6. the daily room rate does not exceed those established by the Wisconsin Department of Health and Social Services or similar agency if in another state.

Successive periods of Injury or Sickness, due to the same or related causes, not separated by return to full-time, active work or in the case of your Dependent, return to normal activities, will be considered one period of disability unless the subsequent period of disability is due to Injury or Sickness entirely unrelated to the causes of the previous disability.

Charges for Skilled Nursing Facility care expenses must be precertified (see page xix).

Online/Internet-Based Physician Visits

You may take advantage of the Preferred Provider Online Physician Visit Program as described on page 55.

Limitations: Benefits are not paid for online/internet-based Physician visits unless provided through the Preferred Provider Online Physician Visit Program.

EXCEPTIONS AND LIMITATIONS

In addition to the General Exclusions on pages 78 through 83 and other limits that apply to specific benefit provisions as described in those sections, Comprehensive Major Medical Benefits do not cover:

1. dental work or surgery, except as specifically provided;

2. eye refractions or the fitting or cost of eyeglasses;

3. cosmetic surgery, except for reparative or reconstructive surgery within 12 months of:

   a. the date of the Injury, if Medically Necessary due to Injury;

   b. the date of breast reconstruction following mastectomy.

   Plastic or reconstructive surgery that is considered Medically Necessary under clinical utilization management guidelines or medical policies approved by the Trustees for the treatment of gender dysphoria will not be deemed cosmetic. The foregoing notwithstanding, the Plan will not cover treatment, services, or supplies deemed cosmetic in these guidelines or policies.

4. treatment of mental or Developmental Deficiency or intellectual disability; or

5. specified medical supplies and durable medical equipment for which you do not obtain Preauthorization and such supplies and equipment are determined not to be Medically Necessary.

VISION CARE BENEFITS

Active and Optional Retiree Classes
Classes C, G, O, P, S, and T

Vision Care Benefits will be characterized under the Plan as an excepted benefit under HIPAA and the Affordable Care Act .

You may obtain reduced prices on lenses, frames, and contact lenses purchased from a Preferred Provider Optical Center as described on page 53.

Vision Care Benefits are payable provided services are rendered or supplies are furnished by an Optician, Optometrist, or Ophthalmologist, and provided that expenses for services and supplies are incurred while eligible under the Plan.

Benefits are payable at the copayment and up to the aggregate maximum amount stated in the Schedule of Benefits for the following covered charges:

1. vision examination;

2. prescription lenses and frames;

3. prescription sunglasses;

4. prescription safety lenses, excluding amounts paid by your Employer;

5. prescription contact lenses, including disposable contact lenses; and

6. LASIK eye surgery.

Exception: For Eligible Persons under age 19, one vision exam every two Calendar Years will not be subject to the aggregate maximum.

Limitations

In addition to General Exclusions on pages 78 through 83, Vision Care Benefits do not cover:

1. orthoptics, vision training, and aniseikonia;

2. services, treatment, or supplies which are payable or furnished under any other coverage with this Fund or any insurance company, or any other medical benefit plan or service plan for which Trustees, directly or indirectly, will have paid for all or a portion of the cost;

3. expenses incurred for services performed or supplies furnished by other than an Optician, Optometrist, or Ophthalmologist; or

4. services, treatment, or supplies rendered or furnished before an individual became eligible or after termination of eligibility of the individual concerned.

DENTAL CARE BENEFITS

Active and Optional Retiree Classes
Classes C, G, O, P, S, and T

Two dental plans currently are provided: Delta Dental of Wisconsin and CarePlus Dental Plan. The Delta Dental Plan is described below. The CarePlus Dental Plan is fully insured by CarePlus Dental and is described in more detail in the CarePlus Dental Certificate referenced in Appendix B.

You have the option once each year of enrolling yourself and your Dependents in the plan of your choice during the open enrollment period in December. Enrollment is for one year, beginning each January 1. To compare benefits available under each alternative, see the Schedule of Benefits and the Description of Services below and in Appendix B. You decide which plan best fits your needs. A current list of participating providers for each option is maintained at the Fund Office and you will be notified of updates. You can receive a copy of this list from the Fund Office upon request at no charge.

Dental Care Benefits will be characterized as excepted benefits under HIPAA and the Affordable Care Act.

Dental Plan 1 – Delta Dental of Wisconsin

You can find a participating network Dentist and access benefit information (such as eligibility and claim status) by calling: 1-800-236-3712 or visiting: www.deltadentalwi.com.

Selecting a Dentist

Delta Dental PPO offers a benefit to those patients receiving treatment from a PPO Dentist. A PPO Dentist List is provided to you periodically from which you may choose a PPO Dentist. However, you and your eligible Dependents may select any Dentist on a treatment-by-treatment basis, whether or not the Dentist is included on the PPO Dentist List. You are free to go to the Dentist of your choice.

HOWEVER, IT IS IMPORTANT TO REMEMBER YOUR OUT-OF-POCKET COSTS MAY BE LOWER WHEN YOU SEE A PPO DENTIST.

Delta Dental PPO Dentists

Delta Dental PPO Dentists have signed a contract with Delta Dental, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs, because you will be responsible only for applicable deductible amounts and coinsurance for benefits. And because these Dentists agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

Delta Dental Premier Dentists

Delta Dental Premier Dentists have signed a contract with Delta Dental, agreeing to accept direct payment from Delta Dental. They also have agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA). However, you will be responsible for deductibles, coinsurance, and fees for services that are not benefits under your particular Group Dental Contract.

Out-of-Network Dentists

If your Dentist has not signed a contract with Delta Dental, claim payments will be calculated based on the MPA, but they will be sent directly to you rather than to the Dentist. You then will need to reimburse your Dentist through the Dentist's usual billing procedure. You will be responsible for any amount in excess of the MPA, as well as any deductible, coinsurance, and fees for services that are not benefits under your particular Group Dental Contract.

Please note that if the fee charged by an out-of-network Dentist is not allowed in full, Delta Dental is not implying that the Dentist is overcharging. Dental fees vary and are based on each Dentist's overhead, skill, and experience. Therefore, not every Dentist will have fees that fall within the MPA.

Maximum Plan Allowance (MPA)

Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific benefit. The MPA will be reduced by any deductible and coinsurance you or your covered Dependent is required to pay.

Delta Dental's MPA varies by region due to contractual arrangements or, in some instances, state regulations. Delta Dental determines an MPA for each CDT code published in the most current version of the Current Dental Terminology (CDT). The MPA established by Delta Dental is developed from various sources, such as contracts with Dentists, input from our dental consultants, the simplicity or complexity of the procedure, and the billed charges for the same procedures by Dentists in the same geographic location.

Filing Claims

To file a claim, simply present your I.D. card to the receptionist at the dental office or give your I.D. number.

Predetermination of Benefits

After an examination, your Dentist may recommend a treatment plan. If the services involve crowns, fixed bridgework, partial/complete dentures, implants, or orthodontics, ask your Dentist to send the treatment plan to Delta Dental, including x-rays. The available benefits will be calculated and printed on a Predetermination of Benefits form, which will be returned to you and your Dentist. The Predetermination of Benefits form is valid for one year from the date issued, provided you maintain your eligibility under the Plan.

Before you schedule dental appointments, you should discuss with your Dentist the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

Predeterminations are required only for Medically Necessary orthodontics, but you are strongly encouraged to obtain a Predetermination of Benefits for the other procedures specified as well.

Optional Treatment

In all cases in which a patient selects a more expensive service than is customarily provided, or for which Delta Dental does not believe a valid need is shown, Delta Dental will pay the applicable percentage of the fee for the service which is adequate to restore the tooth or dental arch to contour and function. The patient is responsible for the entire remainder of the Dentist's fee.

Clerical or Administrative Error

If a clerical error or other administrative mistake occurs, that error will not deprive you of coverage under your Dental Plan that you would otherwise have had. A clerical error or other administrative mistake also will not create coverage for you under your Plan if coverage does not otherwise exist.

Description of Services

Services covered are subject to applicable deductibles, coinsurance, maximums, and out-of-pocket maximums as stated in the Schedule of Benefits, the limitations described within each coverage category, and the Exclusions specified on pages 46 and 47.

In addition, Delta Dental of Wisconsin offers an Evidence-Based Integrated Care Plan (EBICP) that customizes benefits at the individual level by offering additional services to persons who have specific health conditions (diabetes, pregnancy, periodontal disease, high-risk cardiac conditions, suppressed immune system conditions, kidney failure or dialysis conditions, and cancer-related chemotherapy and/or radiation) that can be positively affected by additional care. Call Delta Dental or go to their website to enroll in EBICP if you have any of these conditions.

Diagnostic and Preventive Services

(a) Examinations, no more frequently than twice in a Calendar Year.

(b) Full mouth x-rays once each five years, either individual films or panoramic film, including bitewings.

(c) Bitewing x-rays, no more frequently than once each Calendar Year (limited to a set of four films).

(d) Dental prophylaxis (teeth cleaning), no more frequently than twice in a Calendar Year.

(e) Topical fluoride applications, no more frequently than twice in a Calendar Year.

(f) Space maintainers for retaining space when a primary tooth is prematurely lost.

(g) Topical application of sealants for Dependents ages 6-18.

Basic and Major Services

(a) Emergency treatment to relieve pain.

(b) Extractions, non-surgical and surgical, and other oral surgery (cutting procedures), including pre-operative and post-operative care.

Both scalpel and brush biopsies for the prevention and early detection of oral cancer will be covered.

Services covered under Comprehensive Major Medical Benefits are not covered under this dental Plan.

(c) Amalgam (silver) fillings for molars.

Composite resin (tooth-colored) fillings for front teeth and for molars when the composite resin filling is a new filling or is to replace a defective filling.

(d) Local anesthetic is covered as a part of a dental procedure. General anesthetics or intravenous sedation is a benefit only when billed with covered oral surgery (cutting procedures).

(e) Endodontics, non-surgical and surgical, includes root canal treatments and root canal fillings.

(f) Periodontics, maintenance, non-surgical and surgical, includes procedures necessary for the treatment of disease of the gums and bone-supporting teeth.

(g) Dental implants.

(h) Bleaching (teeth whitening).

(i) All Medically Necessary crowns, inlays, or onlays (paid at seat date, not prep date).

(j) Prosthetics includes fixed bridgework, partial dentures, and complete dentures to replace missing permanent teeth (paid at seat date, not prep date).

(1) Repairs and adjustments to prosthetic appliances.

(2) Porcelain veneers on crowns or pontics are covered benefits for front teeth, bicuspids, and molars.

(3) Coverage for the purpose of replacing a defective existing crown, inlay, onlay, fixed bridge, or partial/complete denture will be provided only after a seven-year period from the date on which it was last supplied.

(4) Fixed bridges and partial/complete dentures are provided where chewing function is impaired due to missing teeth. Complete or partial dentures should be constructed when necessary to replace missing teeth. Fixed bridges will be a benefit only if the use of a removable prosthetic appliance is inadequate.

Routine Orthodontic Services

Routine orthodontic services include orthodontic appliances and treatment, related services for orthodontic purposes, including examinations, x-rays, extractions, photographs, study models, etc., for you, your Spouse, and your Dependent children.

Coverage includes orthodontic treatment in progress. Liability for orthodontic treatment in progress extends only to the unearned portion of the treatment in progress. Delta Dental will be the sole determinant of the unearned amount eligible for coverage.

Repair or replacement of orthodontic appliances is not covered.

If orthodontic treatment is stopped for any reason before it is complete, Delta Dental will pay only for services and supplies actually received. There are no benefits available for charges made after treatment stops.

Delta Dental calculates all orthodontic treatment schedules according to the following formula: 25% of the total case fee is considered the initial or down payment fee to be paid by Delta Dental and the patient at the stated coinsurance percentage. Remainder of the allowed fee is divided by the months of treatment. Monthly payments are made by Delta Dental at the stated coinsurance percentage, up to the orthodontic maximum benefit.

For Eligible Persons under age 19, Medically Necessary orthodontic services must be pre-approved by Delta Dental before treatment begins. If pre-approved, benefits will be payable as stated in the Schedule of Benefits. Medically Necessary orthodontic services are defined as orthodontic treatment that is directly related to and an integral part of the medical and surgical correction of a functional impairment resulting from a congenital defect or anomaly.

Exclusions

Coverage is NOT provided under the Delta Dental Plan for:

(a) Services for injuries or conditions compensable under Worker's Compensation or Employer Liability Law.

(b) Prescription drugs: unless dispensed in the dental office; premedications: unless dispensed in the dental office, and relative analgesia; charges for anesthesia other than charges by a licensed Dentist for administering general anesthesia in connection with covered oral surgery (cutting procedures); preventive control programs; charges for failure to keep a scheduled visit with the Dentist; charges for completion of forms.

(c) Charges by any Hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.

(d) Treatment of or services related to temporomandibular joint dysfunction (TMJ).

(e) Services which are determined to be partially or wholly cosmetic in nature, with the exception of teeth whitening.

(f) Cast restorations placed on eligibles under age 12; prosthetics placed on eligibles under age 16.

(g) Appliances or restorations for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth; for temporary dental procedures; or for splints, unless necessary as a result of accidental Injury.

(h) Treatment by other than a licensed Dentist, the Dentist's employees, or agents.

(i) Dental care injuries or diseases caused by war or acts of war; riots or any form of civil disobedience; injuries sustained while committing a criminal act; injuries intentionally inflicted; dental care injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.

(j) Treatment other than emergencies rendered outside of the United States or Canada.

(k) Replacement of lost or stolen dentures or charges for duplicate dentures.

(l) Those services and benefits not specifically provided under the Contract and/or excluded by the rules and regulations of Delta Dental, including the processing policies, which may change periodically and are printed on the Explanation of Benefits form and Claim Payment Voucher.

(m) Services covered under the Comprehensive Major Medical Benefits.

Claims not submitted to Delta Dental of Wisconsin, Inc. within 90 days of the date of service still will be accepted and processed within 12 months of the date of service.

Grievance Procedures

A grievance is any dissatisfaction with the administration or claims practices of this Plan submitted to Delta Dental. Delta Dental will acknowledge a grievance within 10 days of receiving it. All grievances will be resolved within 30 days from the date the grievance is received. Should Delta Dental be unable to resolve the grievance within that time, we will notify you when a resolution may be expected, within 30 additional days, and the reason for the delay. Delta Dental will notify you in writing of the resolution of the grievance.

You have the right to appear in person before the Grievance Committee to present written and oral information and ask questions of those people responsible for the determination which resulted in the grievance. Delta Dental will provide written notice of the meeting place and time at least seven days before the meeting. In addition, the claims appeal procedures that begin on page 100 of this Summary apply to your Dental Care Benefits.

Dental Plan 2 - CarePlus Dental Benefit

The CarePlus Dental Benefit is fully insured and the Dental Care Group Policy issued to the Fund and the Certificate of Insurance is the complete document of coverage, governs all claims processing and is referenced in Appendix B.

Selecting a Dentist

CarePlus has a network of 85 dental offices in Wisconsin, which include 14 offices operated by Dental Associates and 71 offices operated by Midwest Dental. There is no dental coverage for any services provided out-of-network.

You can find a participating Dentist by visiting www.dentalassociates.com and/or www.midwest-dental.com.

Description of Services

Covered services are subject to applicable coinsurance and maximums stated in the Schedule of Benefits and the limitations and exclusions which follow. Refer to the Certificate of Insurance for a full description of covered services, exclusions and limitations.

PREFERRED PROVIDERS

Active and Retiree Classes
Classes C, E, G, O, P, R, S, T, U, and V

As part of Trustees' ongoing effort to manage health care costs, the Fund participates in a number of Preferred Provider arrangements which offer cost savings to both you and the Fund.

PREFERRED PROVIDER PHARMACY PROGRAM (PPRx)

Express Scripts (formerly Medco) provides full management of the Plan's prescription drug card program. It offers a network of pharmacies where you can use your identification card to purchase your prescription drugs at reduced rates. The network includes several large national chains (such as CVS and Walgreens) and many neighborhood pharmacies. **Wal-Mart Pharmacies are not included in the network.** To see if your pharmacy is in the network, call Express Scripts at: 1-800-939-3753. You also may visit their website at: www.express-scripts.com.

When you purchase prescription drugs at a Preferred Provider Pharmacy (PPRx), benefits are payable subject to the following terms and conditions. For retirees living outside the area, the PPRx arrangement is available throughout the United States.

Formulary

The Trustees have approved a prescription drug “formulary,” which is a list of preferred drugs covered under the PPRx. Medications not listed on the formulary are not covered by the Plan, unless approved in advance by the PPRx. You can find more information about excluded drugs by visiting the Fund's website or contacting the Fund Office.

Quantity Limits

For each prescription purchased at a retail PPRx, you will pay the copayment for generic drugs or for brand name drugs per prescription for up to a 30-day supply as stated in the Schedule of Benefits.

Maintenance prescriptions are available for purchase up to a 90-day supply through the Express Scripts Mail-Service Preferred Provider Pharmacy or the Express Scripts Smart-90 Retail Network. For each maintenance prescription filled through Express Scripts, you will pay the copayment for generic drugs or for brand name drugs per prescription as stated in the Schedule of Benefits. *The Express Scripts Smart-90 Retail Network is a new, voluntary program that allows you to get a three-month (90-day) supply of your maintenance prescription from a Smart-90 retail pharmacy, currently Walgreens. Call Express Scripts at: 1-855-778-1444, or visit their website at: express-scripts.com/3-month. Express Scripts will contact your Physician to get your new prescription. You should have a one-month supply on hand when you place your order.*

Specialty medications (i.e. self-administered injectable and oral medications) may be purchased through Express Scripts' specialty pharmacy, Accredo Health Group, at the copayment stated in the Schedule of Benefits for up to a 30-day supply.

Prior Authorization and Step Therapy

You must obtain prior authorization from the PPRx before filling a prescription for certain medications. If you do not obtain prior authorization before filling the prescription, the Plan will not cover the prescription drug.

The Plan requires step therapy for some medications. Step therapy" is a process that requires you to try the lowest cost drug in the category first. The Plan will cover higher cost drug only if the lower cost drug proves less than fully effective. If you elect the higher cost drug without utilizing the step therapy process, the Plan will not cover the higher cost prescription drug.

The list of drugs that require prior authorization or step therapy changes periodically. You can receive a copy of the current list by contacting Express Scripts.

General Rules

If you use the PPRx while ineligible according to the Plan's Eligibility Rules, the Plan will recover the ineligible payments from you according to the right of recoupment provisions stated on page 77.

You will be responsible for informing the Fund Office if you or your Dependent has primary coverage elsewhere so the Plan can monitor the coordination of benefits provisions. Claims related to prescription drug expenses should be filed with the patient's primary source of health care coverage. If this Plan makes payments and later determines it is not the primary source of coverage, overpayments will be recouped from you.

Covered Expenses

The following are covered expenses upon a Physician's written prescription and dispensed by a licensed pharmacy, unless otherwise specifically excluded. Prior authorization or other requirements may apply. Contact the Fund Office for additional information.

1. Federal legend drugs (that is, drugs the federal law prohibits dispensing without a prescription).

2. Compounded medications of which at least one ingredient is a prescription legend drug and which are deemed Medically Necessary by the PPRx.

3. Insulin.

4. Insulin syringes/needles by prescription.

5. Diabetic supplies, such as test strips, glucose test strips, and lancets (but excluding alcohol swabs).

6. Tretinoin (Retin-A) preparations prescribed for the treatment of acne or when preauthorized by the PPRx.

7. Prescription vitamin preparations, such as prenatal vitamins.

8. Self-administered injectables, except as otherwise excluded.

9. Medications that are required to be purchased through the specialty pharmacy. A list of such medications is maintained at the Fund Office.

10. Infused medications or other specialty medications administered by a Physician, at the Physician's option.

11. Contraceptives for women. Contraceptive methods covered under the PPRx include oral contraceptives, transdermal contraceptives (patch), vaginal hormonal rings, diaphragms, and emergency contraceptives (Plan B). The PPRx does not cover contraceptives available without a prescription, except Plan B emergency contraception. Generic and single-source brand name contraceptives are covered at 100%; multi-source brand name contraceptives are covered subject to the applicable brand name copayment.

12. Preventive care drugs recommended by the U.S. Preventive Services Task Force, Health Resource and Services Administration, or American Academy of Pediatrics, as required under the Affordable Care Act, including:

    a. Over-the-counter (OTC) aspirin;

    b. OTC folic acid;

    c. Smoking cessation products, including OTC nicotine replacement therapy (gum, lozenge, patch, inhaler, and nasal spray) and federal legend drugs (sustained-release bupropion and varenicline), up to two 90-day supplies per 365-day period; and

    d. Federal legend fluoride for Dependent children six months to sixteen years of age whose primary water source is deficient in fluoride.

13. Synagis when preauthorized by and purchased through the specialty pharmacy. When the initial dose is administered while a newborn is Hospitalized, it will be payable under Comprehensive Major Medical Benefits, if preauthorized.

Limitations

The Preferred Provider Pharmacy Program does not cover:

1. implantable contraceptives, regardless of intended use;

2. fertility agents including but not limited to: Pergonal (Menotropins) and Metrodin (Urofollitropins);

3. alcohol deterrents;

4. non-legend (over-the-counter) drugs other than insulin, except as specifically stated;

5. therapeutic supplies, devices, or appliances, including support garments and other non-medicinal substances, except those specified;

6. Experimental or investigational drugs, except as specifically stated;

7. topical minoxidil preparations and Propecia whether commercially prepared or compounded;

8. anorectics (prescription medications for weight loss);

9. medications to treat addictions, including but not limited to, methadone;

10. drugs used to treat sexual dysfunction;

11. covered prescription medications which are not self-administered or are administered in a Hospital, long-term care facility, or other inpatient setting;

12. charges for the administration or injection of any drug;

13. refills of covered drugs which exceed the number of refills the prescription order calls for, or refills after one year from the original date;

14. prescriptions which are not Medically Necessary for the diagnosis or treatment of an Injury or Sickness;

15. drugs purchased at the Hospital pharmacy for the Eligible Person at the time of discharge;

16. drugs purchased at Wal-Mart Pharmacies or any other non-PPRx; and

17. drugs that are excluded from the Plan's formulary unless approved in advance through a formulary exception process managed by the PPRx.

PREFERRED PROVIDER NETWORK

Through the Anthem Blue Cross and Blue Shield Preferred Provider organization, the Fund has access to a network of Hospitals, Physicians, and other health care providers that have contracted to provide many necessary covered services at reduced rates.

Benefits are payable under the Plan for the same type of expenses as are covered at a provider that does not participate in the network and for the same periods of time, subject to the following terms and conditions.

Benefits are payable for covered expenses at the applicable percentage of the Preferred Provider's negotiated charge according to the contract in effect at the time charges are incurred as stated in the Schedule of Benefits.

The list of Preferred Providers in the network is subject to change based on the contractual agreements between the agent and the participating providers. It is recommended that you contact the Fund Office or Anthem prior to incurring covered expenses to make sure the provider you choose is in the Preferred Provider Network. You can call Anthem directly at 1-800-810-2583 or visit their website at www.anthem.com.

While Anthem Blue Preferred POS is your primary PPO network, you also have access to the BlueCard PPO network, a national network which will provide access to additional PPO providers when you incur claims outside Wisconsin.

You also have access to **Anthem's 24/7 Nurseline** to talk with a registered nurse about your health questions and concerns. Just call toll-free: 1-866-670-1565.

In addition, Anthem offers a **Future Moms** program to help you have a safe delivery and a healthy child.

Sign up as soon as you know you are pregnant. Just call toll-free at: 1-877-351-8389. A registered nurse will help you get started. You will get:

- A toll-free number you can use to talk to a nurse coach any time, any day, about your pregnancy. A nurse also may call you from time to time to see how you are doing.
- A book that shows changes you can expect for you and your baby during the next nine months.
- A screening to check your health risk for depression or early delivery.
- Other useful tools to help you, your Physician, and your Future Moms nurse keep track of your pregnancy and help you make healthier choices.
- Free phone calls with pharmacists, nutritionists, and other specialists, if needed.
- A booklet with tips to help keep you and your new baby safe and well.
- Other helpful information on labor and delivery, including options and how to prepare.

PREFERRED PROVIDER OPTICAL CENTER

If you purchase eyewear and contact lenses at a ShopKo Optical Center, you will receive the following reduced rates negotiated by Trustees according to the Preferred Provider agreement in effect:

1. On regularly-priced merchandise, you will receive a 10% discount on eyewear and contact lens purchases.

2. On advertised sale items, you will receive the advertised sale price of the item plus an additional 5% discount on eyewear and contact lens purchases.

Benefits are payable under the Preferred Provider agreement for the same type of eyewear and contact lens expenses as are covered under Vision Care Benefits on page 41 and are subject to the same limitations and maximum amounts stated in the Schedule of Benefits.

Eye examinations are not discounted under this Preferred Provider agreement.

PREFERRED PROVIDER EMPLOYEE ASSISTANCE PROGRAM (EAP)

Because we care about you and recognize that personal issues can affect your job performance and cause you stress, the Plan provides an EAP through ComPsych. The EAP provides personal and work-life support, resources, and information to you and your Dependents. This service is provided at no cost to you and your Dependents. You or your Dependents can access the EAP by calling the ComPsych GuidanceResources toll-free number at: 1-844-393-4984.

Your EAP provides help with the following:

- **Confidential Counseling** provides assessment and short-term counseling service to help address issues such as stress, anxiety, and depression; marital, relationship, and family conflict; grief and loss; substance abuse; or job pressures that you or your Dependents may have.

  When you call the EAP, an intake specialist will get some general information about you and talk with you about your needs. This specialist will provide the name of a counselor who best fits your personal needs. Then, you will set up an appointment to speak with the counselor over the phone or schedule a face-to-face visit. If the counselor determines that your issues can be resolved within five sessions, you will receive free short-term counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling through the EAP, you will be referred to a specialist for longer-term treatment that may be covered under other Plan provisions.

- **Work-Life Solutions** provides qualified referrals and customized resources for child and elder care, moving, pet care, college planning, home repair, buying a car, planning an event, selling a house, and more.

- **Legal Support** provides an attorney “on call” whenever you have questions about legal matters. You can speak with on-staff licensed attorneys about legal concerns such as divorce, custody, adoption, real estate, debt and bankruptcy, landlord/tenant issues, civil and criminal actions, and more. If you require representation, you can be referred to a qualified attorney for a free 30-minute consultation and a 25% discount in customary legal fees.

- **Financial Information** gives you answers to your questions about budgeting, debt management, retirement and estate planning, tax issues, and other money concerns from on-staff CPAs, Certified Financial Planners, and other financial experts.

Online Guidance provides online access to timely expert articles on topics such as relationships, work, school, children, wellness, legal, financial, and free time. You can search for qualified child and elder care, attorneys, and financial planners, as well as ask questions, take self-assessments, and more.

PREFERRED PROVIDER ONLINE PHYSICIAN VISIT PROGRAM

You and your Dependent can consult with a Physician through the Preferred Provider Online Physician Visit Program, LiveHealth Online, in lieu of an in-person Physician visit. You can use LiveHealth Online for common health conditions such as:

- flu
- colds
- sinus infections
- stress
- family health questions

LiveHealth Online providers can prescribe medication, if necessary, *except* for controlled substances and lifestyle drugs.

If you sign up for **Future Moms**, you will also receive a lactation video and postpartum support.

LiveHealth Online visits are generally available 24 hours a day without an appointment on your smartphone, tablet or computer. Visit www.livehealthonline.com or download the free app to access this benefit.

Excluded Services

Excluded services include, but are not limited to, communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to Physicians outside of LiveHealth Online covered providers;
- Benefit precertification; and
- Physician to Physician consultation.

DEATH BENEFITS

Active and Retiree Classes
Classes C, O, P, R, S, T, U, and V
Employees Only

When an Employee dies, Death Benefits are paid subject to the following provisions.

Payment of Benefits.

- **Death.** If you die while you are covered under the Plan, a Death Benefit is payable in the amount specified in the applicable Schedule of Benefits. The Death Benefit will be paid to your designated Beneficiary in one lump sum amount immediately upon receipt of a certified death certificate listing the cause of death and a completed Death Benefit claim form.

- **Accidental Death and Dismemberment.** If you are accidentally injured while covered under the Plan and the Injury solely causes your death or loss of a limb or the sight of an eye within 13 weeks from the date of the accident, an Accidental Death Benefit is payable in addition to the Death Benefit described in the prior paragraph. The amount of the benefit is based on the principal sum specified in the applicable Schedule of Benefits and depends on the severity of the loss as follows:

  Loss of:
  Life .....The Principal Sum
  Both hands or both feet or both eyes ..... Double the Principal Sum
  One hand and one foot; or
  One hand and one eye; or
  One foot and one eye..... Double the Principal Sum
  One hand or one foot or one eye .....One-Half the Principal Sum
  Thumb and index finger of either hand.....One-Fourth the Principal Sum

  The term “loss” as used herein with reference to hand or foot means complete severance through or above the wrist or ankle joint and with reference to eye means the irrecoverable loss of the entire sight thereof. The loss of thumb and index finger means severance of two or more entire jointed sections of both the thumb and the index finger. Benefits will be paid only for the greatest of the losses if more than one loss is sustained as the result of any one accident.

  Losses from injuries received while operating or riding in an aircraft (except while riding as a passenger in a commercial aircraft which is on a regularly scheduled passenger flight) or from suicide or any attempt at suicide are not covered.

  Benefits for accidental death and dismemberment will be paid directly to you, if living, otherwise to your Beneficiary.

Beneficiary. Death Benefits will be paid to your Beneficiary of record. If your marriage is legally dissolved, any prior Beneficiary designation naming your former Spouse as Beneficiary will be deemed null and void. If you want to keep your former Spouse as your Beneficiary, you must complete a new Beneficiary designation form after the date that the marriage is legally dissolved.

You may change your Beneficiary at any time on a form provided by the Fund Office. The Beneficiary's consent is not required. If your designated Beneficiary does not outlive you, the designation of your Beneficiary will be void. You may designate contingent beneficiaries. A new designation or change in Beneficiary normally takes effect on the date you sign the designation. However, if the Fund Office has not received your new Beneficiary designation before Death Benefits are paid, additional Death Benefits are not payable.

Benefit Payment When a Beneficiary is Not Designated. When you die without having named a Beneficiary, or if your Beneficiary dies before payment of the benefit, Death Benefits are paid to your Spouse, if living. If your Spouse is not living or you are not married at the time of your death, benefits are paid to your children in equal shares. If no Spouse or children are living, benefits will be paid to your parents in equal shares. If your parents are not living, benefits will be paid to your brothers and sisters in equal shares. If your brothers and sisters are not living, benefits will be paid to the executor or administrator of your estate or other legal representative if no estate.

Incapacity. If the Trustees determine that any Beneficiary is mentally or physically unable to give a valid receipt for any Death Benefit due under the Plan, such payment will be paid to the Beneficiary's legally appointed guardian, committee, or other legal representative or, if none, to any person or institution then, in the sole judgement of the Trustees, providing for the care and maintenance of such Beneficiary.

In the event a Death Benefit is to be paid to a minor, the Trustees will direct payment to the legal guardian, or if none, to a parent of such minor, an adult with whom the minor maintains the minor's residence, or to the custodian for such minor under the Uniform Gift to Minors Act (if permitted by the laws of the state in which the Beneficiary resides).

Any such payment will be a payment of the Death Benefit to the Beneficiary and will be a completed and full discharge of any liability of the Plan, Fund, or the Trustees, to the extent of such payment.

Assignment of Benefits. Death Benefits are non-assignable.

ACCIDENT AND SICKNESS WEEKLY BENEFITS

Active Classes
Classes C and O
Employees Only

Accident and Sickness Weekly Benefits are payable for Class C and O Active Employees only.

When you are determined to be totally disabled by Trustees, based upon certification by a Physician, Chiropractor, or doctor of dental surgery (D.D.S.), Accident and Sickness Weekly Benefits will be paid to you at the weekly benefit rate and up to the maximum number of weeks payable during any disability as specified in the Schedule of Benefits. During partial weeks of disability, you will be paid at the daily rate of one-seventh of the weekly benefit rate for each day you are disabled. Benefits are payable for disabilities due to nervous and mental disorders, alcoholism, and substance abuse only while Hospital-confined and limited as specified in the Schedule of Benefits. The weekly benefit rate for a pregnancy and/or post delivery-related disability is payable to a mother during pregnancy and/or following childbirth as specified in the Schedule of Benefits.

However, if you are absent from active work because of Injury or Sickness on the effective date of your coverage under the Plan, you will not be eligible for Accident and Sickness Weekly Benefits until the disability ends and you return to full-time active work as defined later in this section.

Benefits begin on the first day of disability due to an Injury or the eighth day of disability due to Sickness. For the purposes of Accident and Sickness Weekly Benefits, only your absence from work which immediately follows the date of the original Injury will be considered for benefits on the first day of the disability. Related symptoms and recurrent symptoms of the Injury will be considered a disability caused by a Sickness and considered for Accident and Sickness Weekly Benefits beginning on the eighth day of the disability.

Reminder. Accident and Sickness Weekly Benefits are subject to withholding for federal Social Security (FICA) taxes.

Limitations. Two or more periods of disability are considered as one unless between periods of disability you have been released by your Physician, Chiropractor, or D.D.S. and have returned to work for an Employer for at least 80 hours, or unless the disabilities are due to entirely unrelated causes.

Accident and Sickness Weekly Benefits are <u>not</u> payable for any disability:

1. **during which you are not under the professional care and regular attendance of a Physician, Chiropractor, or D.D.S.; or**

2. **for any disability for which you are eligible to collect Worker's Compensation benefits or unemployment compensation.**

HEALTH REIMBURSEMENT ACCOUNT (HRA) PROGRAM

ELIGIBILITY

Effective January 1, 2016, retiree prefunding accounts established on behalf of active or retired Employees were converted into a Health Reimbursement Account (HRA) for the affected Employee. Further, you will be eligible to participate in the Plan's HRA Program provided a collective bargaining agreement or other agreement requires an Employer to contribute to an HRA on your behalf and you otherwise meet the eligibility provisions for participation in the Plan on pages 1 through 4.

ACCESS TO FUNDS

Employees. You will have access to the funds accumulated in your Account to obtain reimbursement for out-of-pocket expenses you or your Dependent incur after becoming eligible to participate in and while covered under the Plan or other Minimum Value Coverage and the HRA Program for Qualifying Medical Expenses and Qualifying Premium Expenses. Proof of enrollment in Minimum Value Coverage will be required in a manner to be determined by the Trustees.

Former Employees. You will have access to the funds accumulated in your Account to obtain reimbursement for out-of-pocket expenses you or your Dependents incur while covered under the HRA Program for Qualifying Medical Expenses and Qualifying Premium Expenses.

Dependents. Your Dependents will have access to the funds accumulated in your Account upon your death, provided they were covered as Dependents under the Plan and the HRA Program at the time of your death and they remain covered under the HRA Program. The balance in your Account will be available for use by Dependents to reimburse out-of-pocket expenses incurred for Qualifying Medical Expenses and Qualifying Premium Expenses.

INTENT

The HRA Program is intended to qualify as a self-funded medical expense reimbursement plan under Internal Revenue Code ("Code") Section 105 and regulations thereunder and to comply with guidance issued by the Internal Revenue Service ("IRS") on health reimbursement arrangements in order that benefits paid to Employees will be excludible from their gross income for federal income tax purposes. The HRA Program also is intended to meet the requirements of Code Section 106 in order that Employer contributions on behalf of participating Employees will be excludable from gross income for federal income tax purposes.

DEFINITIONS

Account. The Account established under the HRA Program pursuant to this section on behalf of an Employee.

Former Employees. A former Employee of an Employer and a retired Employee eligible for the Retiree Program.

Minimum Value Coverage. Group health plan coverage that has an actuarial value of at least 60% under standards determined by the IRS and provides substantial coverage of inpatient Hospital and Physician services.

Qualifying Medical Expenses. Substantiated out-of-pocket health care expenses incurred by or on behalf of you or your Dependent, which qualify as medical care under Code Section 213(d) for the diagnosis, care, medication, treatment, or prevention of disease, affecting any structure or function of the body and transportation primarily for and essential for such medical care, as set forth under "Expenses Eligible for Reimbursement" on pages 63 through 67 of this section, with the following requirements:

1. Are required to be paid by you or your Dependent;

2. Are not payable under the regular benefits provided by this Plan or by any other insurance or group health benefits available to you or your Dependent;

3. Have not been previously taken as a tax deduction by you or your Dependent; and

4. Are not expenses for long-term care services.

In no event will Qualifying Medical Expenses be provided in the form of cash other than reimbursement.

Qualifying Premium Expenses. Coverage costs such as self-payment contributions or premiums for continuation of coverage when you do not work sufficient hours to maintain eligibility; COBRA continuation coverage; coverage under the Retiree Program; and substantiated premium payments for qualified long-term care insurance, dental insurance, and vision insurance. Premium Expenses do not include premiums for accident or health insurance as defined in Code Section 213(d); fixed indemnity, cancer or Hospital indemnity insurance premiums paid by an Employer; premiums that are or could be deducted pre-tax through a Section 125 cafeteria plan (including a Spouse's plan), or other premiums specified in the Exclusions on pages 67 and 68.

However, for Former Employees and your surviving Dependents, Qualifying Premium Expenses also will include Medicare Parts B and D Medicare Supplement policies, group Medicare Advantage premiums, and group health plan premiums (unless the premium is paid or could have been paid pre-tax from another source).

In no event will Qualifying Premium Expenses be provided in the form of cash other than reimbursement.

FUNDING

HRAs initially were funded by converting the balance of your former Employee Prefunding Account into an HRA on your behalf. Thereafter, the HRA Program is funded solely with Employer contributions made to the Fund on behalf of active Employees and allocated to your Account while eligible. No Employer contributions are made to your Account after you terminate employment or retire, unless you return to covered employment. Under no circumstances will benefits under the HRA be funded directly or indirectly with salary reductions or other contributions under a Code Section 125 cafeteria plan maintained by the Fund or an Employer.

The Fund, at the discretion of the Trustees, may divert a portion of the Employer contributions made to the HRA Program on behalf of Employees to the general Fund to offset increased health costs under the Fund.

ACCOUNT

Balance Carry-Over

If there is any balance remaining in the Account after all reimbursements have been paid for the Calendar Year, such balance will be carried over to a subsequent Calendar Year. You, your Dependent, or any other individual may not assign, transfer, or alienate any interest in the Accounts.

General

You may access amounts in your Account for the reimbursement of Qualifying Medical Expenses and Qualifying Premium Expenses you incur while an active Employee (including while maintaining coverage through self-payments) or former Employee.

Statement

You will be provided with a statement showing the balance in your Account periodically.

FORFEITURE OF ACCOUNTS

The Accounts are subject to the following forfeiture rules:

Upon Death

Upon your death, your Account balance (if any) immediately becomes available to your Dependents who satisfy the requirements on page 59. The balance in the Account will be available for use by the Dependents until the earliest of when the Account balance is zero, the account is forfeited under the Plan's rules, or the Plan ends. In no event will amounts in the Account be paid in cash to any person for other than reimbursement of an eligible expense (for example, there are no lump sum distributions of the Account balance as a death or termination benefit). The Account balance will be forfeited to the Plan if you have no Dependents.

Forfeiture of Inactive Account

The Fund will forfeit an Account if it is inactive for five consecutive years. An Account is considered "inactive" if there is no Employer contribution paid into the Account or reimbursement paid from the Account. The forfeiture time period will be tolled during periods in which you or your Dependent has opted-out of Plan coverage pursuant to rules adopted by the Trustees.

Forfeiture of Account Due to Opt-Out

If prior to January 1, 2017, you or your Dependent elected to opt-out of the HRA Program pursuant to Affordable Care Act requirements, the Account was forfeited.

CONTINUATION OF ACCOUNT UNDER COBRA

If you and your Dependent's coverage ends due to a COBRA qualifying event, each Qualified Beneficiary will be given the option of electing to continue the HRA Program, if the Qualified Beneficiary elects COBRA Continuation Coverage for Health Care Benefits.

ACA OPT-OUT OF ACCOUNT

Annual Opt-Out

You will be given the opportunity to opt-out of the HRA Program and waive future reimbursements from your Account annually while you remain covered under the Plan to the extent required under the Affordable Care Act.

If you elect to opt-out of your Account, the Account will be frozen as of the date of opt-out and any HRA contributions received on your behalf will be forfeited to the Plan until the Account is reinstated. A frozen Account will be reinstated on the earlier of:

1. the January 1 following the 12-month period to which the opt-out applied, unless you elect to opt-out for a subsequent 12-month period; or

2. your death.

Loss of Plan Eligibility

You will be given the opportunity to opt-out of the HRA Program and waive future reimbursements from your Account upon loss of Plan eligibility. If you opt-out of your Account, the Account will be frozen as of the date of opt-out. The frozen Account will be reinstated if you regain Plan and HRA Program eligibility. However, the Account will remain subject to the forfeiture rule for inactive accounts described on page 61.

Becoming Eligible for Retiree Coverage

You will be given the opportunity to opt-out of the HRA Program and waive future reimbursements from your Account upon becoming eligible for retiree coverage. If you opt-out of your Account, the Account will be frozen as of the date of opt-out. A frozen Account will be reinstated on the earlier of:

1. the January 1 following the 12-month period to which the opt-out applied, unless you elect to opt-out for a subsequent 12-month period;

2. loss of coverage under other group health plan coverage due to loss of eligibility or termination of the group health plan; or

3. your death.

Death of Employee or Former Employee

Your Dependents will be given the opportunity to opt-out of the HRA Program and waive future reimbursements from your Account upon your death. If your Dependent opts-out of the Account,

any amounts remaining in the Account will be frozen as of the date of opt-out. The frozen Account will be reinstated on the January 1 following the 12-month period to which the opt-out applied, unless your Dependent elects to opt-out for a subsequent 12-month period. Any amounts remaining in the Account will forfeit to the Plan upon the Dependents' death.

NON-CONTRIBUTORY COVERED EMPLOYMENT

If you engage in work considered Covered Employment within the geographic jurisdiction of the United Brotherhood of Carpenters International Union for an employer that is not a contributing Employer and not subject to a written agreement requiring contribution into the Plan (either directly or indirectly through reciprocity), your Account will be forfeited on the last day of the month in which such employment commenced or is discovered, whichever is earlier. If you continue employment, of any kind, with a former contributing Employer for whom your worked prior to such Employer withdrawing from the Plan, and the Employer is no longer obligated to contribute to the Plan under the terms of a written agreement or under the National Labor Relations Act during a period of bargaining, your Account will be forfeited on the last day of the month in which the contributing Employer's obligation to contribute to the Plan ceases. However, if you reinstate eligibility in the Plan within 12 months of the date your Account is forfeited, the Plan will reinstate your Account balance. The Board of Trustees, under the appeal process of the Fund, will have discretion to make all findings of fact and conclusions with respect to the forfeiture of an Account.

EXPENSES ELIGIBLE FOR REIMBURSEMENT

You may receive reimbursement from your Account for Qualifying Medical Expenses or Qualifying Premium Expenses that are incurred while you or your Dependents are eligible for coverage under the HRA Program. An expense is "incurred" when you or your Dependent is furnished the medical care or services giving rise to the claimed expense. The determination of whether an individual is a Dependent whose Qualifying Medical Expenses and Qualifying Premium Expenses are covered by the HRA Program will be made at the time such expenses are incurred. You cannot be reimbursed for any medical expenses that you incurred before the HRA Program was established or before you became a Participant in the HRA Program. Qualifying Medical Expenses must not be reimbursed by insurance or by any other source, must be expenses that you or your Dependent is required to pay, and must not be expenses for which you or your Dependent has taken (or will take) a deduction for income tax purposes.

However, amounts paid in advance for Qualifying Medical Expenses will be deemed incurred to the extent permitted by the IRS (e.g., orthodontia expenses). As allowed by law, the HRA Program may reimburse uninsured orthodontia services before services are provided, but only to the extent that you or your Dependent actually has made the payment in advance of the service in order to receive the service. Where you or your Dependent is pre-paying for services, the date of service is deemed to be the date of payment. The following rules will apply to an advance payment for orthodontia services:

1. The payment must be made specifically in order for orthodontia services to be made. Payments for services rendered in previous Plan Years, or prepayments for services not to be rendered until a later Plan Year, are not reimbursable.

2. The reimbursement will be made in a lump sum payment, under a payment plan, or as services are incurred.

3. Documentation Requirements:

   (i) For one-time lump sum payments for services not yet incurred, you or your Dependent must submit documentation from the orthodontist showing the name of the person receiving the treatment, the beginning date of the treatment, the contracted amount, the amount payable by insurance, and the amount paid. Credit card slips, bank statements, or cancelled checks are not valid documentation under IRS rules.

   (ii) For payment plans, you or your Dependent must submit for the first claim the payment contract with the orthodontist showing the name of the person receiving the treatment, the beginning date and ending date of the treatment, total contracted amount, scheduled monthly payment amount, and total amount of the first payment (including any initial fees or records fees) not paid by insurance. For each claim thereafter, you must submit documentation from the orthodontist showing the amount paid, amount payable by insurance, and the name of the person receiving the treatment. If you submit a monthly payment plan, you cannot accelerate payments to receive a lump sum payment for the balance.

   (iii) For services that have been incurred, you or your Dependent must submit documentation from the orthodontist showing the name of the person receiving the treatment, the date of the treatment, and the service fee.

Qualifying Medical Expenses

The HRA Program may reimburse eligible Qualifying Medical Expenses including: out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance; medical care expenses not covered by the Plan; and including, but not limited to, the following expenses, specified by Code Section 213(d) as eligible for reimbursement:

1. Abdominal supports;

2. Abortion;

3. Acupuncture;

4. Air conditioner (when necessary for relief from an allergy or for relief from difficulty in breathing);

5. Alcoholism treatment;

6. Ambulance;

7. Arch supports;

8. Artificial limbs;

9. Autoette (when used for relief of Sickness/disability);

10. Birth control pills (by prescription);

11. Blood tests or transfusions;

12. Braces;

13. Cardiographs;

14. Christian Science Practitioner;

15. Contact lenses;

16. Contraceptive devices (by prescription);

17. Convalescent home (for medical treatment only);

18. Crutches;

19. Dental treatment, dental x-rays, or dentures;

20. Diagnostic fees;

21. Diathermy;

22. Drug addiction therapy;

23. Drugs, prescription and over-the-counter medications for treatment of medical conditions with a written prescription (except for insulin);

24. Elastic hosiery (prescription);

25. Eyeglasses;

26. Fees paid to health institute prescribed by a Physician;

27. FICA and FUTA tax paid for medical care service provided by a nurse or other attendant;

28. Fluoridation unit;

29. Guide dog;

30. Gum treatment;

31. Hearing aids and batteries;

32. Hospital bills;

33. Hydrotherapy;

34. Insulin treatments;

35. Lab tests;

36. Lactation supplies, including breast pumps and other breastfeeding supplies that assist lactation;

37. Lead paint removal;

38. Lodging (away from home for outpatient care);

39. Metabolism tests;

40. Nursing services of practical nurses and registered nurses (including board and meals for the attendant);

41. Operating room costs;

42. Oral surgery;

43. Organ transplants (including donor's expenses);

44. Orthopedic shoes;

45. Oxygen and oxygen equipment;

46. Physician services, including the services of an anesthetist, Chiropractor, dermatologist, gynecologist, neurologist, obstetrician, Ophthalmologist, Optician, Optometrist, osteopath, pediatrician, podiatrist, psychiatrist, psychoanalyst, psychologist; psychotherapist, or surgeon;

47. Physiotherapist services;

48. Postnatal services and prenatal care;

49. Radium therapy;

50. Special school costs for the handicapped;

51. Spinal fluid test;

52. Splints;

53. Sterilization;

54. Telephone or television equipment to assist the hard-of-hearing;

55. Therapy equipment;

56. Transportation expenses related to health care;

57. Ultra-violet ray treatment for medical purposes;

58. Vaccines;

59. Vasectomy;

60. Vitamins (if prescribed);

61. Wheelchair; and

62. X-rays.

Exclusions

Medical expenses that are ineligible for reimbursement from the HRA Program are specified by Code Section 213(d) and are not Qualifying Medical Expenses or Qualifying Premium Expenses. Ineligible expenses include, but are not limited to the following:

1. Advance payment for services [except for certain orthodontia payments and other advance payments permitted under Internal Revenue Code Section 213(d)];

2. Athletic club memberships;

3. Automobile insurance premium allocable to medical coverage;

4. Boarding school fees;

5. Bottled water;

6. Commuting expenses of a disabled person;

7. Cosmetic surgery and related procedures;

8. Cosmetics, hygiene products, and similar items;

9. Diaper service;

10. Domestic help;

11. Fitness programs, weight loss programs, and exercise equipment, unless prescribed by a Physician;

12. Funeral, cremation, or burial expenses;

13. Health programs offered by resort hotels, health clubs, and gyms;

14. Illegal operations and treatments, and illegally procured drugs;

15. Insurance premiums for health care coverage (except as specifically noted on page 60);

16. Long-term care expenses (although premiums for qualified long-term care insurance are covered);

17. Massage therapy (unless prescribed);

18. Maternity clothes;

19. Premiums for fixed indemnity cancer insurance, fixed indemnity Hospital insurance, life insurance, income protection, disability, loss of limbs, sight, or similar benefits;

20. Scientology counseling;

21. Social activities;

22. Special foods or beverages, or a specially designed car for the handicapped other than an autoette or special equipment;

23. Swimming pool;

24. Teeth whitening;

25. Travel for general health improvement;

26. Tuition and travel expenses for a problem child to attend a particular school;

27. Unreasonable amounts of over-the-counter drugs and medicines (i.e., stockpiling, is prohibited under guidance from the IRS);

28. Vitamins, unless prescribed by a Physician; and

29. Weight loss programs for general health.

CLAIMS FOR REIMBURSEMENT BENEFITS

You or your Dependent must submit reimbursement requests to the Fund Office with a properly completed request form. You or your Dependent may obtain the form by contacting the Fund Office. A copy of the itemized bill when applicable also must be included. If you or your Dependent has other health care coverage, regardless of whether the other coverage is primary or secondary, you must submit an Explanation of Benefits (EOB) from the other health care plan with the request form.

If there is any question as to whether an expense for reimbursement is allowable, or if Medical Necessity or any other documentation is required, you or your Dependent is solely responsible for obtaining the necessary substantiation or documentation, including any expense associated with obtaining such substantiation or documentation.

You or your Dependent may request reimbursement for expenses under the HRA Program pursuant to a schedule that the Trustees adopt and which the Trustees will communicate. The Trustees also may impose other terms and conditions on the payment of benefits, including establishment of minimum reimbursement requests. Expenses must be submitted so that they are received no later than 36 months following the date on which the expenses are incurred.

Upon receipt of a properly completed reimbursement request, the Plan will issue a reimbursement check and will deduct the amount of the reimbursement from your Account. If there is an insufficient amount in your Account to cover the reimbursement request, it is your responsibility to resubmit the balance during the next quarter if you then have a sufficient balance in your HRA.

If a claim for reimbursement is denied, you or your Dependent will be notified of the denial and your right to appeal the denial under the claims procedures for the Plan.

ORDERING RULES

Plan Coverage

If a Qualifying Medical Expense also is covered under the Plan, the expense first must be submitted to the Plan and then submitted to the HRA Program.

Health Flexible Spending Account or Health Reimbursement Arrangement

If you or your Dependent's expenses are covered under the HRA Program and a health flexible spending account under a Code Section 125 cafeteria plan, or under another health reimbursement arrangement, such claims must be submitted to the health flexible spending account or other health reimbursement arrangement before they are submitted to the HRA Program.

COORDINATION OF BENEFITS

The HRA Program will not be considered a group health plan for coordination of benefits purposes under the Plan, and its reimbursement benefits will not be taken into account when determining other benefits payable under this Plan or benefits payable under any other health plan except for Medicare. The use of benefits under the HRA Program may be restricted under some circumstances for active Employees or their Spouses or Dependents who are enrolled in Medicare pursuant to the Medicare Secondary Payer Rules.

The eligibility of an Employee or Dependent for prescription drug benefits under the HRA Program will terminate effective on the date of enrollment in a Medicare Part D plan, including enrollment in an Employer Group Waiver Plan (EGWP).

RECIPROCITY AND PARTIAL EMPLOYER CONTRIBUTION PAYMENTS

The Trustees will adopt policies for applying reciprocal contributions and Partial Employer Contribution payments.

INTEREST AND EXPENSES

The Trustees may assess a reasonable fee for Account maintenance and for expenses related to the processing of reimbursements. The Trustees in their discretion may award earnings generated by the assets in the Accounts to the Accounts.

SELF-PAYMENT ACCOUNT AUTOMATIC DEDUCTION

You may authorize the Plan in advance on written forms issued by the Plan to automatically deduct from your Account the amount necessary to satisfy a monthly self-payment obligation. The Plan will notify you if there are insufficient assets in your Account to satisfy the monthly self-payment amount. You may terminate your automatic deduction election by submitting a written request to the Fund Office. The Plan will terminate the automatic deduction election as soon as administratively feasible after receiving a termination notice.

GENERAL PROVISIONS

All Classes of Eligible Persons

COORDINATION OF BENEFITS WITH OTHER PLANS

This section is applicable to all benefits of the Plan, except Death or Accidental Death and Dismemberment Benefits and the insured organ transplant benefits.

If you or your eligible Dependents are entitled to benefits under any Other Group Plan, the amount of benefits payable by this Plan will be coordinated so that the aggregate amount paid will not exceed 100% of the health care expenses incurred. In no event will this Plan's payment exceed the amount which would have been paid if there were no other plan involved. Benefits payable under another plan include the benefits that would have been payable even if no claim actually was filed with the other plan.

Definitions for this Coordination of Benefits Provision

1. "Other Group Plan" will mean any plan providing benefits or services for or by reason of medical, dental, or vision care under: group insurance; group practice, Blue Cross, Blue Shield, or other prepayment coverage; labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; governmental employees group programs, including Medicare, or coverage required or provided by law; or automobile reparation (no-fault) insurance required under any applicable law and provided through arrangements other than a court decree establishing financial responsibility for medical expenses, but only to the extent of benefits required under such no-fault insurance law.

2. The term "Other Group Plan" will be construed separately as to each policy, contract, or other arrangement for benefits or services and separately as to any part which may consider benefits or services of other plans in determining its benefits and any part which does not. An individual may have other health plan coverage containing a provision, or some similar provision whose purpose is to provide primary coverage only for a small amount of expenses, well below the maximum benefit available under the plan if no other coverage is available (collectively, a "sub-plan provision"). The effect or intent of a plan with a sub-plan provision is to transfer the much larger secondary coverage to the other health plan with which such plan is coordinating benefits. In the event this Plan is coordinating benefits with a plan containing a sub-plan provision, the sub-plan provision will be treated as arbitrary and capricious and a subterfuge and will be ignored, resulting in coordination of benefits with the plan, sub-plan, or similar provision that would apply if the Eligible Person did not have coverage under this Plan.

3. "Allowable Expense" means any necessary, reasonable, and customary item of expense, at least a part of which is covered under one of the plans covering the Eligible Person for whom a benefit request is made. If a plan provides benefits in

the form of services or supplies instead of payment in cash, the reasonable monetary value of the services rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid.

Order of Benefit Calculation. In the case of duplicate group coverage for an Eligible Person, you must report such duplicate group health plan coverage. If another plan or portion of a plan covering the Eligible Person does not contain a coordination of benefits provision, then that plan must determine the benefits it pays before this Plan does.

When duplicate coverage arises and both plans contain a coordination of benefits or similar provision, this Plan has established the following rules to decide which group plan will calculate and pay its benefits first (pay "primary"). The **first** rule that describes which plan determines its benefits is the rule that will be followed. For example, if the order of benefit determination can be determined by Rule 1, none of the subsequent rules are applicable.

For the purposes of these rules, the term Employee includes retired Employee, unless the context requires otherwise.

1. If a person is eligible as an employee in one plan and as a Dependent in another (unless otherwise mandated by Medicare), the plan covering the person as an employee is primary.

2. If a person is eligible as a Dependent child in two plans, and the parents are married or living together, the plan covering the person as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in a Calendar Year will be determined first.

   If a plan containing the "birthdate" rule is coordinating with a plan which contains the former gender-based rule and as a result the plans do not agree on the order of benefit determination, the birthdate rule will determine the order.

3. When parents are divorced, separated, or not living together, the order of benefit determination is as follows:

   a. The plan of the parent having primary physical placement[1] of the Dependent child pays first;

   b. If the parent having primary physical placement has remarried, the order is:

[1] Includes parents who last had primary physical placement of children as defined on pages 88 and 89.

1) the plan of the parent having primary physical placement[1];

2) the plan of the Spouse of the parent having primary physical placement[1];

3) the plan of the parent not having primary physical placement[1];

4) the plan of the Spouse of the parent not having primary physical placement[1].

However, if there is a court decree which directs that one of the parents is responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any order given here.

If the parent with responsibility for health care expenses does not have health coverage for the expenses of the Dependent child, but the Spouse of that parent does, then the plan of that parent's Spouse is the primary plan.

If the court decree states that both parents will be responsible for the Dependent child's health care expenses, benefits will be coordinated according to the birthdate rule.

If the court decree states that the parents have joint custody without specifying that one parent is responsible for the Dependent child's health care expenses, benefits will be coordinated according to the birthdate rule.

4. The plan that covers the person as an active employee, that is, an employee who is neither laid off or retired, or a Dependent of such employee, is the primary plan. The plan covering that same person as a retired or laid-off employee or Dependent of such employee is the secondary plan.

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the benefits of the plan which covers the person as an employee, or as that person's Dependent, will be primary and the continuation coverage will be secondary.

6. If rules 1., 2., 3., 4., or 5. do not determine which plan will calculate and pay its benefits first, then the plan that has covered the person for the longer period of time is primary.

Benefits of this Plan will be reduced to the extent necessary to prevent the other group plan from refusing to pay benefits available under its policy. Additionally, if a sub-plan exists, the sub-plan is not or cannot be ignored pursuant to 2. on page 71; and the sub-plan is found by the Board of Trustees or a court of competent jurisdiction to apply, then this Plan expressly limits its secondary coverage available to the Eligible Person to the same dollar amount contained in, or calculated under, the sub-plan provision.

[1] Includes parents who last had primary physical placement of children as defined on pages 88 and 89.

Coordination of Benefits for Eligible Stepchildren. Special rules apply to coverage for your eligible stepchildren, which are described on page 88 of this Summary.

The Board of Trustees and its designees have discretion to interpret the Plan and determine whether benefits are payable under the Plan. This discretion will include, but not be limited to, discretion to interpret the language of other plans and also to determine whether other plans consist of a single plan or multiple plans. The discretion also will include, but not be limited to, discretion to determine whether a sub-plan provision exists. The Board of Trustees' determination in this regard will be binding and final for all purposes, including but not limited to all coordination of benefits purposes, and only will be reversed if a court of competent jurisdiction determines that the Board of Trustees' determination is arbitrary and capricious.

MEDICARE PROVISIONS

Eligible Persons who are retired or disabled are required to enroll in Part A and Part B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") in the event they become entitled to such coverage by reason of attained age, qualifying disability, or End Stage Renal Disease (ESRD).

Retirees also will become eligible for Medicare Prescription Drug Benefits. Unlike Medicare Benefits, retirees are not required to enroll in Medicare Prescription Drug Benefits. If the retiree does not enroll in Medicare Prescription Drug Benefits, he will continue to be eligible for the Plan's prescription drug benefits, provided he is otherwise eligible. If the retiree or his Dependent does enroll in Medicare Prescription Drug Benefits, special eligibility provisions apply as described on page 7.

In no event will benefits paid by the Plan exceed the applicable amounts stated in the Schedule of Benefits. Also, the combined amounts payable under Parts A and B of Medicare and the Plan will not exceed the eligible expenses incurred by the Eligible Person as the result of any one Injury or Sickness. Benefits payable by Parts A and B of Medicare include those which would have been payable if the Eligible Person had properly enrolled when eligible to do so.

For Eligible Persons for whom Medicare is the primary source of coverage, the benefits payable under this Plan for services incurred at a Veterans Administration (VA) facility for non-service-connected disabilities will be reduced by the amount that would have been payable by Medicare had the services been rendered by a Medicare-approved facility.

For Eligible Persons for whom Medicare is the primary source of coverage, the benefits payable under this Plan for services otherwise covered by Medicare, but which are privately contracted with a provider, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

For Eligible Persons for whom Medicare is the primary source of coverage and who have enrolled in a Medicare Advantage Plan: the benefits payable under this Plan for services otherwise covered by Medicare, but which are not covered under the Medicare Advantage Plan because the Eligible Person did not obtain services at a network provider and/or did not comply with that plan's managed care requirements, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

To facilitate Plan payments in the absence of Medicare payments, it may be necessary for Trustees to estimate Medicare payments.

Neither you nor the Plan is responsible for paying any charges which exceed legal limits set by law for Medicare payments.

Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Under the Plan Through Self-Payments. In the event a person eligible under the Plan solely because of self-payments becomes initially entitled to Part A or B of Medicare due to attained age or a qualifying disability (other than ESRD), benefits payable under this Plan will be reduced by the amount of benefits paid or payable under Part A or B of Medicare.

If such person subsequently becomes entitled to Medicare due to ESRD, Medicare will continue to be the primary source of coverage.

Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Under the Plan Through Employer Contributions. Plan benefits are not reduced for persons eligible under Class C or Class O through Employer contributions even though they also may become initially entitled to Part A or B of Medicare due to attained age or a qualifying disability (other than ESRD).

If such person subsequently becomes entitled to Medicare due to ESRD, the Plan will continue to be the primary source of coverage for the full 30-month coordination period specified in the following subsection.

However, an Employee or Dependent Spouse eligible under Class C or Class O through Employer contributions who becomes initially entitled to Medicare due to attained age will have the right to reject the Plan and retain Medicare as their primary source of coverage. In such case, the Plan is legally prohibited from supplementing Medicare coverage.

Persons Initially Entitled to Medicare by Reason of ESRD and Eligible Under the Plan Through Either Self-Payments or Employer Contributions. In the event an Eligible Person becomes initially entitled to Part A or B of Medicare because of ESRD (or when ESRD-based Medicare entitlement occurs simultaneously with attained age or other qualifying disability-based entitlement), benefits are provided subject to the following terms. The same terms apply if an Eligible Person becomes initially entitled to Medicare due to ESRD and subsequently becomes entitled to Medicare due to attained age or another qualifying disability.

1. The Plan will be the primary source of coverage for covered charges incurred for up to 30 consecutive months from the date of ESRD-based Medicare entitlement.

2. Benefits payable under the Plan beginning with the 31st month of ESRD-based Medicare entitlement will be reduced by the amount of benefits paid or payable under Part A or B of Medicare.

SUBROGATION/REIMBURSEMENT

Whenever the North Central States Regional Council of Carpenters' Health Fund has been or is providing Hospital, medical, dental, vision, or disability benefits ("Benefits"), as a result of the occurrence of any Injury, Sickness, or death which results in any possible recovery of, including but not limited to, indemnity, compensation, damages, remuneration, or restitution from any party, including an insurer, including uninsurance and underinsurance coverage, no-fault insurance, personal injury and protection insurance, or Worker's Compensation Benefits, the Fund may make a claim or maintain an action against such party.

By virtue of accepting such Benefits, the Eligible Person assigns to the Fund the right to make a claim against such party to the extent of the amount of such Benefits.

An Eligible Person must not do anything after the loss for which the Benefits were provided to prejudice the Fund's right of recovery. An Eligible Person must promptly advise the Administrative Manager of this Fund in writing whenever a claim against any party is made by or on behalf of the Eligible Person with respect to any loss for which Benefits were, or are being, received from the Fund.

The recipient of Benefits has an obligation to provide the Fund or its designee with the names and addresses of all potential parties and their insurers, adjusters, and claim numbers, as well as accident reports and any other information the Fund requests. If the information requested is not provided, the Fund in its discretion may withhold future benefit obligations pending receipt of the requested information.

The Eligible Person or the Fund may make a claim against a party or commence an action against a party and join the other as provided under Section 803.03 of the Wisconsin Statutes or applicable state or federal law. Each will have an equal voice in the prosecution of such claim or action.

The proceeds from any settlement or judgment in any claim made against any party will be allocated as follows:

1. First, a sum sufficient to fully reimburse the Fund for all Benefits advanced will be paid to the Fund. No court costs or attorneys' fees may be deducted from the Fund's recovery without prior expressed written consent of the Fund. This right will not be defeated by any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorneys' Fund Doctrine" or any other similar doctrine or theory.

2. Any remainder will be paid to the Eligible Person on whose behalf claim is made.

3. The Fund will receive a credit, up to the full amount of any remainder paid to the recipient of Benefits pursuant to the prior paragraph, to apply against any future Benefit obligations arising out of the Injury, Sickness, or death which was the subject of the claim which resulted in the settlement or judgment.

The preceding allocation of proceeds will be paid from the first dollar of any proceeds received and will have a priority over competing claims regardless of whether the total amount of the recovery of the Eligible Person, or those claiming under him, is less than the actual loss suffered, or less than the amount necessary to make the Eligible Person, or those claiming

under him, whole. The Fund's rights will not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Garrity Doctrine," "Rimes Doctrine," or any doctrine purporting to defeat the Fund's rights by allocating the proceeds exclusively, or in part, to non-medical expense damages.

Furthermore, such allocation will apply to claims of Dependents of Eligible Employees covered by the Fund, regardless of whether such recipient was legally responsible for expenses of treatment.

In the event an Eligible Person makes a recovery in a claim from any party and the proceeds are not allocated in accordance with the prior paragraphs, Trustees will have the right to make a claim for Reimbursement, including but not limited to claims for restitution, unjust enrichment, or a constructive trust over any recovery by the Eligible Person to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, the Eligible Person, the Eligible Person's attorney, or any other individual or entity, or to take a credit on future Fund obligations to the Eligible Person to the extent of such Benefits. Such credit will not be limited to future obligations of the Fund to the actual recipient of such Benefits but also may be taken against any future obligations to the Eligible Employee or Dependents.

RIGHT OF RECOUPMENT

Whenever payments have been made by this Plan to, or on the behalf of, any Participant or to, or on the behalf of, any Dependent or Beneficiary of a Participant or to, or on the behalf of, any other Eligible Person which payments would not have been payable ("unauthorized payments"), or payments in excess of the maximum amount applicable at such time ("overpayments"), under the Summary and/or under the Eligibility Rules or under any announced policy adopted by the Trustees, the Plan will have the right to recover such unauthorized payments or overpayments, plus related amounts (e.g., interest and costs), from any one or more of the following sources:

1. the Participant, Dependent, Beneficiary, or other Eligible Person to whom or on whose behalf such unauthorized payment or overpayment was made, including by making deductions from benefits payable to them, or on their behalf to third parties, or causing other adjustments of benefits or payments, whether insured under the Plan or self-insured, which may be payable in the future;

2. family members of such Participant, Beneficiary, Dependent, or other Eligible Person or such person's estate or legal representative; or

3. any service provider, insurance company, or other entity to whom such unauthorized payment or overpayment was made.

The Fund will be permitted to pursue legal and equitable remedies (e.g., an equitable lien by agreement, constructive trust, offset, or setoff) to recover excess payments and related amounts. The Fund may recover excess payments and related amounts by offsetting amounts payable to the Participant, Beneficiary, Dependent, or other Eligible Persons including their family members. The Trustees will select the interest rate for any erroneous payments or overpayments.

GENERAL EXCLUSIONS

The General Exclusions apply to all benefits provided under the Plan. In addition, specific limitations may apply to certain benefits and are stated within the appropriate benefit section.

General Exclusions for all Plan benefits include the following. No Plan benefits are provided for:

1. Any Injury or Sickness:

   a. covered by any Worker's Compensation Law (Worker's Comp.) or Occupational Disease Law; or

   b. which is work-related but the Employer is not covered by or subject to Worker's Comp.; or

   c. which is work-related and where the person was self-employed and performed such work for remuneration.

      (This exclusion does not apply to Accidental Death and Dismemberment Benefits.)

   Trustees may, however, in their sole discretion, provide Plan benefits to Eligible Persons in cases in which:

   a. a question has arisen as to whether or not such Injury or Sickness is occupational or work-related and covered by Worker's Comp.; and

   b. where such issue actually is pending before the Wisconsin Department of Workforce Development or before a similar agency in other states (collectively, DWO), in a Worker's Comp. proceeding; and provided

   c. the Eligible Person executes in favor of Trustees an enforceable written undertaking, satisfactory to and approved by counsel for the Fund, stating that if the DWD or the courts determine or render a decision that the Injury or Sickness is, in fact, covered by Worker's Comp., or if a compromise settlement as to such issue is approved by the DWD, then the Eligible Person will reimburse and repay to the Fund all benefits paid by the Fund to the Eligible Person for such Injury or Sickness.

   If the Eligible Person fails to reimburse the Fund, the Fund, at its discretion, may:

   a. take a credit against future claims of the Eligible Person and Dependents up to the amount of the Fund's expenditures of such expense;

   b. initiate legal proceedings to recover the Fund's expenditures; or

   c. in addition to the Fund's right of recoupment described on page 77, exercise the Fund's right to reimbursement, including but not limited to claims for restitution, unjust enrichment, or a constructive trust over any recovery by the

Eligible Person, to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, the Eligible Person, the Eligible Person's attorney, or any other individual or entity.

In the event of such compromise settlements, the Chairman and Secretary-Treasurer of the Fund's Board of Trustees are authorized, jointly, (or may delegate such authority to the Administrative Manager) to consent to such compromise settlement of any dispute or issue pending before the DWD concerning the occupational or work-connected status of an Injury or Sickness of an Eligible Person, including settlements under which benefit payments have been authorized and the compromise settlement provides for Reimbursement to the Fund of less than all such benefit payments. However, the compromise settlement also must be agreed to by the Eligible Person and the Eligible Person's attorney (if any), the Eligible Person's Employer, and the Employer's Worker's Compensation carrier.

2. Expenses incurred for care for armed service-connected disabilities furnished within any facility of, or provided by, the United States Department of Veterans Affairs or Department of Defense.

3. Expenses incurred for care for non-service-connected conditions furnished within any facility of, or provided by, the United States Department of Veterans Affairs or Department of Defense for which there has not been furnished to the Fund Office required details and supporting papers.

4. Injury or Sickness caused by war or any act of war (declared or undeclared).

5. Loss incurred while engaged in military service (including naval or air service).

6. Elective procedures, including elective cosmetic procedures, unless specifically included.

7. Expenses the patient otherwise is not required to pay.

8. Any charge for services or supplies in excess of Reasonable Expenses.

9. Expenses for services and supplies which are not incurred for the actual treatment of an Injury or Sickness, such as those provided for developmental deficiencies.

10. Charges for artificial life support in excess of $5,000 unless Medically Necessary or incurred more than five days after legal or clinical death.

11. Medical expenses incurred in an automobile accident if automobile insurance was not obtained by the Eligible Person as required by state law. (Payment will be considered on the amount that exceeds no-fault coverage.)

12. Charges for elective termination of pregnancy, unless specifically included under the Plan.

13. Psychological testing, except as specifically stated.

14. Alternative medicine.

15. Aggregate costs in excess of $5,000 for Experimental medical treatment and procedures, except specifically as may be provided for under the Plan or as may be authorized by the Board of Trustees pursuant to advice provided by a Physician retained by Trustees as medical consultant. However, to the extent required under the Affordable Care Act, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny, limit or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the Approved Clinical Trial; and will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial. Qualified Individuals must use a Preferred Provider if a Preferred Provider is participating in an Approved Clinical Trial and the Preferred Provider will accept the Qualified Individual as a Participant in the Approved Clinical Trial

16. Expenses incurred for services, treatment, or surgical procedures rendered in connection with an overweight condition or condition of obesity including prescription drugs, diet plans, and related Physician visits, except as required by the Affordable Care Act or otherwise specifically included under the Plan.

17. Charges for medical services and treatment outside of the United States unless incurred for care of an emergency condition as determined by the Plan. An "emergency condition" means the sudden and unexpected onset of a change in an Eligible Person's physical or mental condition which, if not treated immediately, could reasonably be expected to result in the following as determined by the Plan:

    a. loss of life or limb;

    b. significant impairment to bodily function; or

    c. permanent dysfunction of a body part.

    Treatment of emergency conditions rendered outside the United States that fall within these parameters will be payable subject to the Plan's deductible and copayment provisions and will be limited to charges deemed reasonable in the United States. Such charges must be submitted in English.

18. Charges incurred by an Eligible Person for the reversal or attempted reversal of a previous sterilization procedure.

19. Genetic testing including genetic testing to determine carrier status, therapy, and engineering except as specifically provided or as required by the Affordable Care Act.

20. State and local taxes incurred on covered expenses.

21. Shipping and handling for charges incurred on covered expenses.

22. Charges incurred for the completing of claim forms (or forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

23. Complications resulting from a procedure or surgery that is excluded under the Plan, including but not limited to, obesity and aesthetic cosmetic surgery.

24. Any drug or medicine which has not been approved by the United States Food and Drug Administration by issuance of a New Drug Application or other formal approval, except as specifically provided.

25. Any medical or surgical procedure which is not considered a generally accepted procedure by the medical community in the United States.

26. Services provided by a person who ordinarily resides in your home or is a family member.

27. Custodial care and maintenance care.

28. Any artificial means to achieve pregnancy, including but not limited to, invitro fertilization, GIFT, artificial insemination, and all related fertility testing and treatment, except as specifically provided.

29. Charges incurred for any special education rendered to any Eligible Person regardless of the type of education, except as specifically stated.

30. Charges for telephone conversations/telephone consultations.

31. Any losses incurred by an Eligible Person at a time that an Eligible Person owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by an Eligible Person, or where such person has failed to honor the Plan's right of subrogation or reimbursement or otherwise failed to cooperate with the Plan as specified.

32. Charges incurred for home births.

33. Immunizations, except as described under "Covered Immunizations." Immunizations for the purpose of travel or employment, or required because of where you reside, or any other reasons not listed, are not covered.

34. Charges incurred for a surrogate pregnancy, except as required by law.

35. Therapies or testing for learning disabilities.

36. Non-emergency transport, except as specifically stated.

37. Replacement supplies used with durable medical equipment, except as specifically stated.

38. Replacement of lost or stolen equipment.

39. Rentals of durable medical equipment that exceed the purchase price.

40. Replacement of lost or stolen medications or medications confiscated or seized by Customs or other authorities.

41. Any charges for physical exams or preventive care, regardless of purpose, beyond the amount stated in the Schedule of Benefits, unless specifically stated.

42. Skilled Nursing Facility services or confinement when primary use of the facility is as a place of residence or when treatment is primarily custodial.

43. Charges for missed appointments.

44. Nutritional counseling, except for diabetes management and as required by the Affordable Care Act.

45. Panniculectomy or removal of excess skin due to weight loss, weight loss surgery, or pregnancy, except as specifically stated.

46. Medications, meal plans, exercise programs for weight control or weight loss.

47. Bariatric surgical procedure(s) for obesity or morbid obesity and complications following bariatric surgery.

48. Circumcision, unless for a newborn or determined to be Medically Necessary for a medical condition.

49. Equipment not primarily intended to improve a medical condition or Injury, including but not limited to: air conditioners or air purifying systems, arch supports, communication aids, elevators, exercise equipment, massage devices, overbed tables, commodes, toilet seat raisers, bath benches or chairs, sanitary supplies, telephone alert systems, vision aids, whirlpools, portable whirlpool pumps or sauna baths, standers, strollers.

50. Expenses related to normal activities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.

51. Homemaker, chore work, or housekeeping services.

52. Habilitation.

53. Long-term care.

54. Private-duty nursing.

55. Routine foot care.

56. Any charge for services or supplies that are not Medically Necessary, except as specifically stated.

57. Expenses you or your Dependent incur for Injuries or Sickness resulting from or sustained as a result of a commission, or attempted commission, of a felony except that expenses resulting from acts of domestic violence or from a medical or mental health condition are not excluded to the extent required by law.

TERMINATION OF PLAN

This Plan may be terminated:

1. in its entirety--by Trustee action and when Trustees determine that the Trust Fund is inadequate to carry out the intent and purpose of the Trust Agreement or is inadequate to meet the payments due, or to become due, to Participants and/or Dependents under the Trust Agreement or under the Summary;

2. as to Employees (and their Dependents) in a particular collective bargaining unit--by agreement of the Union(s) and Employer association (or individual Employers, where applicable) which negotiate the labor agreements covering such collective bargaining units; or

3. for a particular Employer and its non-bargaining unit or Alumni Employees--Trustees determine that an Employer, signatory to a participation agreement to cover non-bargaining unit or Alumni Employees, no longer meets the requirements of such participation agreement and related policies.

In the event of termination, Trustees will follow the terms of the Trust Fund Agreement and applicable law.

PROHIBITION AGAINST ASSIGNMENT TO PROVIDERS

An Eligible Person or Beneficiary may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. The prohibition against assignment of such rights includes, but is not limited to, the right to:

1. receive benefits;

2. claim benefits in accordance with Plan procedures and/or federal law;

3. commence legal action against the Plan, Trustees, Fund, its agents, or Employees;

4. request Plan documents or other instruments under which the Plan is established or operated;

5. request any other information that a Participant or Beneficiary as defined in Section 102 of ERISA may be entitled to receive upon written request to a Plan Administrator; and

6. any and all other rights afforded an Eligible Person or Beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

This provision does not have the effect of prohibiting the claims administrator or Trustees from mailing payment of benefits under the Plan directly to a provider of services or supplies.

COMPLIANCE WITH INTERNAL REVENUE CODE SECTIONS 105 AND 106

The Plan will take sufficient measures to preserve the tax-favored advantages provided by Code Sections 105 and 106.

GENETIC INFORMATION NONDISCRIMINATION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

NONDISCRIMINATION PROVISIONS AGAINST ANY HEALTH CARE PROVIDER ACTING WITHIN THE SCOPE OF LICENSE OR CERTIFICATION

To the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment, or setting for an item or service, the Plan will not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.

INTERPRETATION BY TRUSTEES

The Plan will be administered solely by the Trustees or its delegate. Benefits under this Plan will be paid only if the Board of Trustees or the delegate of Trustees (including, but not limited to, the Administrative Manager) decides in its discretion that the applicant is entitled to them. The Trustees (or its delegate) have the sole and absolute discretion to construe and interpret the Plan and all of its provisions, rules, regulations, or procedures. The Trustees also have the sole and absolute discretion to determine eligibility for participation in and benefits under the Plan and Trust. Any exercise by the Trustees of their discretionary authority will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan. All questions or controversies in connection with the Plan or its operation will be submitted to the Board of Trustees for decision.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

In order to implement the terms of the Plan, the Trustees may, without the consent of or notice to any person, release or obtain information from any person to or from any insurance company or other organization or program providing benefits or services that the Trustees deem necessary and consistent of this obligations under applicable law. Any person claiming benefits under the Plan will provide to the Trustees information necessary to implement this rule.

FACILITY OF PAYMENT

Whenever payments payable under the Plan have been paid by any other plan, the Trustees, in their own discretion, may pay to such other plan any amounts they determine are warranted. Such amounts paid will be deemed to be benefits paid under the Plan and, to the extent of such payments, the Trustees will be fully discharged from liability under the Plan.

GENERAL DEFINITIONS

Whenever used in this Summary, the following terms are understood to have the meanings described as follows.

Administrative Manager means the entity or individual designated by the Trustees who has the executive authority to control and manage the administration of the Plan by assisting in carrying out Trustees' policy decisions, communications, recordkeeping, and accounting. Trustees hire and maintain an administrative staff which is under the direction and supervision of the Administrative Manager.

Affordable Care Act means the Patient Protection and Affordable Care Act, as amended, and corresponding guidance.

Alumni means persons who once participated in the Plan because of work performed under a collective bargaining agreement requiring contributions to this Fund and who currently perform work which is not covered by such agreement for:

1. one or more Employers that are parties to the collective bargaining agreement requiring contributions to the Fund;

2. the Plan; or

3. the Union.

Approved Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is:

1. Approved or funded by one of the following:

   a. the National Institute of Health;

   b. the Centers for Disease Control and Prevention;

   c. the Agency for Health Care Research and Quality;

   d. a cooperative group or center of any of the preceding entities or the Departments of Defense or Veterans Affairs;

   e. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; and

   f. the Departments of Veterans Affairs, Defense, or Energy if certain conditions are met.

2. Conducted under an investigational new drug application reviewed by the FDA; or

3. A drug trial that is exempt from having such an investigational new drug application.

Bargaining Unit Employee means any Employee represented by the Union and working for an Employer, and with respect to whose employment an Employer is required to make contributions to the Trust Fund.

Beneficiary has the same meaning in this Summary as in the Trust Agreement.

Calendar Year means that period commencing at 12:01 a.m. central standard time on the date the Eligible Person first becomes eligible and continuing until 12:01 a.m. central standard time on the following January 1st. Each subsequent Calendar Year will be the period from 12:01 a.m. central standard time on January 1st to 12:01 a.m. central standard time on the next following January 1st. The time will be that time at the address of Trustees.

Chiropractor means a licensed Chiropractor operating within the scope of such license.

Classes of Eligible Persons means all the classifications of coverage under the Plan as follows:

Class C (Active): Employees (and their Dependents) of Employers obligated by a collective bargaining agreement to pay contributions to this Fund.

The term "Employees" includes Bargaining Unit Employees and, provided the Employer is party to an approved participation agreement, certain Non-Bargaining Unit or Alumni Employees.

Class O (Active Employees of Industrial Employers): An Industrial Employer's Bargaining Unit and Non-Bargaining Unit Employees (and their Dependents) who satisfy the applicable Eligibility Rule requirements.

Class E and G (COBRA):

1. *Class E* – An Eligible Person continuing coverage for Comprehensive Major Medical Benefits through COBRA self-payments.

2. *Class G* – An Eligible Person continuing coverage for Comprehensive Major Medical Benefits, Vision Care Benefits, and Dental Care Benefits through COBRA self-payments.

Class P, R, S, T, U, and V (Retired): Retired Employees and their Dependents (both those who are eligible for Medicare and those who are not) continuing coverage through self-payments according to the Eligibility Rules.

Please Note: Early retirees/Spouses who become initially entitled to Medicare due to End Stage Renal Disease will remain in an early retiree Class (R or P) until the full 30-month coordination period specified in the Medicare Provisions on page 74 has elapsed (even if such person turns age 65 during that period).

Medicare-eligible retirees and/or Spouses in Classes U, S, V, and T who cover children under age 26 will have their self-payment amount based at the level required for retired Employees and Spouses who are not Medicare-eligible (Classes R and P).

Covered Employment means employment in Covered Work for a Participating Employer.

Covered Work means the type of work covered by a participating Union's building, construction, and industrial labor contracts.

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

Dependent means the Eligible Employee's:

1. Spouse (except if legally separated).

2. Natural child or children or legally adopted children under age 26. With respect to an adopted child, the child is a Dependent under this definition effective on the date of placement with the Eligible Employee.

3. Other Dependents, including:

    a. Stepchildren who are under age 26 and who meet the restrictions specified in this subsection. The Plan's obligation to provide benefits will be secondary to any obligation of either or both of the natural parents created by court order or judgment of divorce or of legal separation. The stepparent will promptly provide a copy of any such court order or judgment and, in the event there is imposed such obligation on the natural parent or parents, the stepchildren first will seek payment or provision of benefits pursuant to said obligation of the natural parent(s). If collection under, or enforcement of, the natural parent's obligation is impossible or impracticable, the Plan will provide benefits the same as for legally adopted children. The Fund will be assigned the right to enforce such obligation so as to obtain Reimbursement from the responsible natural parent or parents, or from their insurer, for benefits provided.

    b. Foster children who are under age 26 and who are placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

    c. Grandchildren who are under age 19 or under age 23 as long as their primary activity is that of a full-time student (carrying at least 12 credits) enrolled in and attending classes in an accredited school. Grandchildren must: receive more than one-half their annual financial support from you; have the same principal residence as you for more than one-half the Calendar Year except for temporary absences; and be a lineal Dependent. A grandchild who is 19 or older and under age 23 must verify school enrollment on Plan forms.

        However, if your grandchild loses full-time student status while covered under the Plan due to a Medically Necessary leave of absence, as certified in writing

by a Physician, your grandchild will remain eligible under the Plan in accordance with ERISA section 7.14 and Code section 9813 (known as Michelle's law).

d. Children, regardless of age, who are incapable of self-sustaining employment by reason of intellectual disability or physical handicap and such incapacity began prior to age 26. The Fund will continue the health coverage for such child so long as the Employee's coverage remains in force and such incapacity continues. Proof of the incapacity must be submitted to Trustees within 31 days of the date such Dependent child's coverage otherwise would terminate due to attainment of age 26 or, in the case of a newly Eligible Employee, within 31 days after the Employee first becomes eligible under the Plan. Such 31-day period may be extended by Trustees for good cause as determined by Trustees.

e. A child who is named in a Qualified Medical Child Support Order or National Medical Support Notice as an alternate recipient with which you and the Fund are obligated to comply.

A child of an Eligible Employee must be a citizen or resident of the United States. This provision does not exclude an adopted child who does not meet the citizenship criteria if the child has the same principal residence as the Eligible Employee, is a member of the Eligible Employee's household, and the Eligible Employee is a citizen or national of the United States.

Trustees will recognize their obligation to comply with Qualified Medical Child Support Orders under applicable federal regulations.

This definition is meant to be consistent with IRS Rules.

When both husband and wife are employed by the same or another Employer and are Eligible Employees under this Plan, each will be covered under the Plan as an Employee but also will be eligible for coverage as a Dependent of their respective Spouse. Children may be covered as Dependents of both the husband and wife. When an Employee is under the age of 26 and has one or two parents also covered under the Plan, the Employee will be eligible for coverage as a Dependent under the parents' Plan.

Benefits are payable according to the coordination of benefits provisions on page 71.

Developmental Care means care primarily related to assisting in the development of those skills related to developmental deficiencies and not rehabilitative in nature. This care is not an effort to restore previously developed skills that were lost or impaired due to Injury or Sickness.

Developmental Deficiency means conditions which prevent persons from reaching the level of intellectual, speech, motor, or physical development normally expected for the person's age.

Eligible Employee means any Employee or former Employee of an Employer who is eligible for benefits in accordance with the applicable Eligibility Rules of the Fund as adopted from time to time.

Eligible Person means either the Eligible Employee or the eligible Dependent.

Employee has the same meaning in this Summary as in the Trust Agreement.

Employer has the same meaning in this Summary as in the Trust Agreement.

Experimental means those treatments, procedures, drugs, and devices that have not yet gained acceptance by the medical community as standard therapy at the time the service is rendered. Experimental treatments are those that are characterized by at least one of the following at the time of treatment:

1. The treatment is undergoing clinical investigation and is not generally recognized by the medical community as established and accepted practice.

2. The treatment has not yet been approved by the Food and Drug Administration or other governmental agency.

3. Any treatment which is: of uncertain therapeutic benefit; restricted to use in clinical trials; or of questionable safety and effectiveness for the Eligible Person's condition.

Fiscal Year means the 12 months beginning any January 1st and ending the following December 31st.

Home Health Care Agency means a public or private organization which is primarily engaged in providing skilled nursing and therapeutic services on an at-home basis. A Home Health Care Agency must be supervised by professional medical personnel and be licensed or approved by the state or locality in which it operates.

Hospice Facility means a facility primarily engaged in providing care to terminally ill individuals, and which follows the requirements for a Hospice Facility under Title 18, Section 1861(dd) and its regulations. A "Hospice Facility" is defined in Section 418.3 and Sections 418.50 through 418.98(b) and Section 418.100, but excluding Section 418.60. A "Hospice Facility" must satisfy the requirements for covered services as defined in Sections 418.200 through 418.204, and may be required to comply with requirements concerning eligibility and certification of terminal illness as defined in Sections 418.20(b) and Section 418.22, and may be reimbursed at different rates for the categories of care as defined in Section 418.302(b).

Hospice Program means a program which:

1. has received necessary authorization from the Health Systems Agency to initiate hospice care in a given area;

2. is eligible to satisfy accreditation requirements as developed by the National Hospice Organization and/or the Joint Commission on the Accreditation of Health Care Organizations; and

3. meets the following criteria:

    a. The patient and family are seen as the unit of care.

b. An integrated, centralized, administrative structure ensures continuity of care for home care and inpatient care.

c. Volunteers are used to assist paid staff members.

d. Direct provision of care is provided by an interdisciplinary team consisting of Physicians, nurses, social workers, chaplains, and volunteers.

e. 24-hour-per-day, 7-day-per-week service is available.

Hospital means a place which is licensed as a Hospital (if licensing is required by law), which is operated for the care and treatment of resident inpatients and which has a laboratory, registered nurses continually on duty, and an operating room where major surgical operations are performed by Physicians. In no event will the term "Hospital" include an institution or that part of an institution which is used principally as a clinic, convalescent home, rest home, nursing facility, or home for the aged. Hospital also means an institution which has accommodations for resident bed patients, facilities for the treatment of nervous or mental disorders, and a resident psychiatrist on duty. Hospital further includes institutions specializing in the treatment of alcoholism or substance abuse, provided the institution is licensed by the governmental authority if licensing is required. To be covered, these Hospitals also, as a regular practice, must charge patients for the expense of confinement.

Industrial Employee means a Bargaining Unit Employee of an Industrial Employer or a Non-Bargaining Unit Employee of an Industrial Employer who has entered into a participation agreement with the Board of Trustees and such participation agreement has been approved by Trustees. Industrial Employees are covered under Class O.

Industrial Employer means any Employer, as defined in the Trust Agreement, whose Employees perform work classified as "industrial" and who is required to pay contributions to the North Central States Regional Council of Carpenters' Health Fund pursuant to a collective bargaining agreement with a Union participating in the Fund or an approved participation agreement as stated on pages 1 and 2.

Injury means accidental bodily damage which requires treatment by a Physician and which results in loss independently of Sickness and other causes.

Intensive Care Unit means a special area of a Hospital exclusively reserved for critically ill patients requiring constant observation which, in its normal course of operation, provides:

1. personal care by specialized registered nurses and other nursing care on a 24-hour-per-day basis;

2. special equipment and supplies which are immediately available on a standby basis; and

3. care required but not rendered in the general surgical or medical nursing units of the Hospital.

The term "Intensive Care Unit" also will include an area of the Hospital designated and operated exclusively as a coronary care unit, cardiac care unit, or neonatal intensive care unit.

Life-Threatening Condition is a disease or condition likely to result in death unless the disease or condition is interrupted.

Lifetime, with reference to benefit maximums and limitations, means the aggregate covered expenses incurred while an Eligible Person is covered under the Plan. Under no circumstances will "Lifetime" mean during the lifetime of an Eligible Person, even after the person's eligibility ends.

Medically Necessary means a service or supply which:

1. is appropriate and consistent with the diagnosis of an Injury or Sickness in accordance with accepted standards of community practice; and

2. could not have been omitted without adversely affecting the person's condition or the quality of medical care.

The Trustees, or employees or agents of the Trustees authorized by the Trustees, in their discretion will interpret what is Medically Necessary. The Trustees, or their authorized employees and/or agents, will take into account relevant information including, but not limited to, clinical utilization management guidelines or medical policies approved, accepted or endorsed by the Trustees or the organization(s) selected by the Trustees to serve as the Plan's utilization review or management firm.

Non-Bargaining Unit Employees means an Employer's full-time Employees who perform work which is not covered by a labor contract requiring contributions to this Fund and who, therefore, are not represented by a labor organization and who are not Alumni. A full-time Employee is one who is regularly employed by an Employer 25 or more hours per week.

Optician, Optometrist, and **Ophthalmologist** means any person who is qualified and currently licensed (if licensing is required in the state) to practice each such profession by the appropriate governmental authority having jurisdiction over the licensure and practice of such profession, and who is acting within the usual scope of that practice.

Participant means any Employee or former Employee of an Employer as defined in the Trust Agreement who is eligible to receive any benefit from this Fund in accordance with the Eligibility Rules or other regulations that Trustees may establish.

Participating Employer means an Employer as defined in the Trust Agreement and who is required to pay contributions to the North Central States Regional Council of Carpenters' Health Fund pursuant to a collective bargaining agreement or an approved participation agreement.

Personal Pronoun Usage. Words used in this Summary in the masculine or feminine gender will be considered as the feminine gender or masculine gender respectively, where appropriate.

Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

Physician means a person who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of such practice. "Physician" will be interpreted to include, but will not be limited to, a doctor of

medicine, osteopath, podiatrist, chiropodist, Ophthalmologist, and doctor of dental surgery. Additionally, to the extent required by the Affordable Care Act, "Physician" will include any person who performs services covered by the Plan if such person is licensed to provide such services and is operating within the scope of his or her license when providing such services.

Plan means the document adopted by Trustees, as amended from time to time, which incorporates the provisions, terms, and conditions under which benefits are paid and the schedules of benefits which are in effect.

Plan Year means the 12 months beginning any January 1st and ending the following December 31st.

Preauthorization means it is recommended that certain procedures/services are reviewed for Medical Necessity and approved for coverage BEFORE they are performed.

Precertification means the Participant, Physician, or Hospital must notify CMS when an Eligible Person is scheduled for a non-emergency inpatient admission.

Preferred Providers means:

1. Physician, Dentist, registered nurse, physical therapist, or other licensed health care provider;

2. Hospital;

3. alcohol and substance abuse treatment facility;

4. hospice;

5. laboratory;

6. outpatient surgical facility;

7. pharmacy;

8. business selling or renting durable medical equipment; or

9. any other source,

who/which alone or as part of a group enter into a contract with Trustees agreeing to be compensated for those services and supplies covered under this Plan according to the terms of such contract. Such parties are Preferred Providers for the duration of their contract.

The types of Preferred Providers currently include the following:

"Preferred Provider Pharmacy (PPRx)" means a pharmacy which participates in the Preferred Provider Pharmacy Program and is party to a contract with Trustees. Currently, Trustees have a contract with Express Scripts under which: retail stores participating in the nationwide Express Scripts network (excluding Wal-Mart Pharmacies) are the designated Preferred

Provider Pharmacies; and Express Scripts is the designated Mail-Service Preferred Provider Pharmacy.

"Preferred Provider Network" means any of the Hospitals, Physicians, or other health care providers which contract with Trustees directly or through their agents from time to time. Anthem Blue Cross and Blue Shield is the Preferred Provider Network.

"Preferred Provider Optical Center" means the optical center which is party to a contract with Trustees, currently ShopKo Optical.

"Preferred Provider Employee Assistance Program (EAP)" means the EAP which is party to a contract with Trustees, currently ComPsych Guidance Resources.

"Preferred Provider Online Physician Visit Program" means the organization which contracts with the Trustees from time to time to provide Physician visits to you and your Dependents via the internet, currently LiveHealth Online.

Prevailing Contribution Rate means the hourly contribution rate determined by the Board of Trustees as needed to support the benefit Plan Trustees adopt for active Employees performing Covered Employment.

Employer contribution rates required pursuant to such labor contracts with Unions and which are less or greater than the "Prevailing Contribution Rate" will be prorated when crediting contributions for purposes of determining active Employees' eligibility and the need for self-payments, unless a reciprocity agreement dictates otherwise.

Qualified Individual is an Eligible Person who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other Life-Threatening Condition and either: (1) the referring health care professional is a participating provider and has concluded that the Eligible Person's participation in the Approved Clinical Trial would be appropriate; or (2) the Eligible Person provides medical and scientific information establishing that participation in the Approved Clinical Trial would be appropriate.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law which has the force and effect of law under applicable state law, that:

1. provides for child support payments related to health benefits with respect to the child of a Plan Participant, or requires health benefit coverage of such child by the Plan, and is ordered under such state domestic relations law; or

2. enforces a state law relating to medical child support payments with respect to the Plan; and

3. creates or recognizes the right of a child as an alternate recipient--who is recognized under the order as having a right to be enrolled under the Plan--to receive benefits derived from such child's relationship to an Eligible Employee who is a Participant in the Plan; and

4. includes the name and last known address of the Participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided; and

5. does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; andhas been determined to be a Qualified Medical Child Support Order or National Medical Support Notice under reasonable procedures adopted and uniformly applied by the Plan. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Fund Office upon request at no charge.

Participants and beneficiaries may obtain a free copy of the Plan's procedures for reviewing QMCSOs entitled, "North Central States Regional Council of Carpenters' Health Fund Qualification of Medical Child Support Orders - Guidelines for Attorneys and Parties-in-Interest" by calling the Fund Office.

Reasonable Expense means the charges incurred for services and supplies which are Medically Necessary for treatment and which are "regular and customary." "Regular and customary charges" will be determined as follows:

1. With respect to a Preferred Provider, the applicable charge under the Preferred Provider's agreement with the Trustees.

2. With respect to any provider that does not qualify as a Preferred Provider located within the geographic area served by the Preferred Provider Network, the amount the Fund would have paid to a Preferred Provider for the same service or supply.

3. With respect to a provider outside the geographic area served by the Preferred Provider Network, the amount, as determined by the Trustees or their designee, to be the lowest of:

    a. the usual charge by the Physician for the same or similar service or supply, as determined by the Preferred Provider; or

    b. the Physician's actual charge.

Routine Patient Costs include items and services typically provided under the Plan for an Eligible Person not enrolled in an Approved Clinical Trial. However, such items and services do not include: (1) the investigational item, device, or service itself; (2) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (3) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

Sickness means a disease, disorder, or condition which requires treatment by a Physician, including pregnancy and childbirth and any related conditions.

Skilled Nursing Facility means a specially qualified facility that has staff and equipment to provide:

1. skilled nursing care performed by, or under the supervision of, licensed nursing personnel;

2. skilled rehabilitation services, such as physical therapy, performed by, or under the supervision of, a professional therapist; and

3. other related health services.

Spouse means an Eligible Employee's Spouse pursuant to a valid marriage certificate that is recognized in the state in which the marriage was performed.

Total Disability:

1. As used in regard to Accident and Sickness Weekly Benefits, the term "Total Disability" means any disability commencing while the Eligible Employee is covered under the Plan and resulting from Injury or Sickness which prevents the Eligible Employee from performing any and every occupational duty, including "light work." To be considered as having a "Total Disability," the Eligible Employee must not be receiving remuneration for any other work or service.

2. As used for purposes other than that stated in the prior paragraph 1., the term "Total Disability" means an Injury or Sickness commencing while the Eligible Person is covered under the Plan that prevents an Eligible Person from engaging in gainful employment.

Totally and Permanently Disabled: an Employee will be considered "Totally and Permanently Disabled" upon receipt of a disability benefit from the North Central States Regional Council of Carpenters' Pension Fund or another construction industry pension fund.

Trust Agreement means the North Central States Regional Council of Carpenters' Health Fund Trust Document, as amended, and is incorporated by reference.

Trust Fund or **Fund** means the entire trust estate of the North Central States Regional Council of Carpenters' Health Fund as it may, from time to time, be constituted.

Trustees means the Board of Trustees of the North Central States Regional Council of Carpenters' Health Fund.

Uniformed Services means the United States Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Union has the same meaning in this Summary as in the Trust Agreement.

You means any Participant.

HOW TO APPLY FOR BENEFITS

PRE-SERVICE CLAIMS:

It is recommended that you obtain Preauthorization for certain services and supplies as specified on page xviii or Plan benefits will be denied if determined not to be Medically Necessary. Precertification is required for any non-emergency Hospital confinement and any non-emergency inpatient surgery to be eligible for the maximum level of benefits. Also, you must contact the Fund Office for prior approval for all organ transplants. These claims are called, "pre-service claims," which means any claim that requires approval of the benefit in advance of obtaining medical care. Pre-service claims may be submitted initially by telephone or in writing to CMS.

There are special provisions in the Claims Procedure Regulations for "urgent care claims" (referred to under the Plan as "emergencies"), but, by definition, these provisions do not apply because the Plan does not require prior approval of emergency admissions.

POST-SERVICE CLAIMS:

Any claim for benefits that is not a pre-service claim is considered a "post-service claim." Post-service claims include those for emergency Hospital admissions. You must notify the Plan within 48 hours following an emergency admission. You must submit all other post-service claims in writing within 90 days of the occurrence of the accident or Sickness, or as soon thereafter as is reasonably possible. In no event (except in the absence of legal capacity) can a claim be submitted later than two years after the claim was required to be received by the Fund Office.

Claim forms can be downloaded from the Fund's website: www.ncscbf.com.

Once you become eligible, you will receive an identification card from the Fund which identifies you and contains the name and address of the North Central States Regional Council of Carpenters' Health Fund. The Fund's Administrative Manager certifies eligibility, processes claims, and makes the benefit payments. When you obtain health care services or supplies, make sure you present your ID card to the provider. Your ID card will give the provider all the information necessary to submit the claim for payment. If the provider does not submit the claim, you must do so yourself. Post-service claims must be submitted in writing to the appropriate party as follows:

Send all insured organ transplant claims to:

OT Claims Department
P.O. Box 3028
Costa Mesa, CA 92626

Send all dental claims to the dental program in which you are enrolled:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481-0828

CarePlus Dental
3333 North Mayfair Road, Suite 311
Wauwatosa, WI 53222

Send all claims for vision, Medicare-eligible retirees, and Death and Accidental Death and Dismemberment Benefits to:

Fund Office
North Central States Regional Council of Carpenters' Health Fund
P.O. Box 4002
Eau Claire, WI 54702

Send all other medical claims for services obtained in Wisconsin to:

Anthem Blue Cross and Blue Shield
P.O. Box 34210
Louisville, KY 40232-4210

Send all other medical claims for services obtained outside Wisconsin to your local Blue Cross and Blue Shield Plan.

Claims should be complete, including, at a minimum:

1. Fund name (North Central States Regional Council of Carpenters' Health Fund);
2. Participant's name and identification number;
3. full name (including "Jr.," if applicable) and date of birth of the Eligible Person who incurred the covered expense;
4. name and address of the service provider;
5. federal tax identification number of provider;
6. diagnosis of the condition;
7. procedure or nature of the treatment;
8. date of and place where the procedure or treatment has been provided; amount billed and the amount of the covered expense not paid through coverage other than this Plan, as appropriate; and
9. evidence that substantiates the nature, amount, and timeliness of each covered expense that is in a reasonably understandable format and is in compliance with all applicable law.

Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address. A general request for an interpretation of Plan provisions will not be considered a claim for benefits. Pre-determined amounts you must pay, such as a prescription drug copayment or amount required because of use of a network or non-network provider, will not be considered a claim for benefits subject to the claims procedure. However, if you feel that you have been charged an improper dollar or percentage copayment (for example through the Preferred Provider Pharmacy Program), you may submit a formal appeal to the Fund Office in writing within 180 days to have your claim reviewed according to the appeal procedures stated on pages 100 through 112.

You or your authorized representative can pursue a claim. You may authorize a representative by obtaining an Authorized Representative Designation form from the Fund Office and returning the completed form to the Fund Office..

Benefits are paid directly to the provider of service, unless you direct otherwise in writing when the claim is submitted and you attach proof of payment.

ACCIDENT: If the claim you are submitting is the result of an accident, you must complete an Injury form. You must provide the name and address of any third party who may be liable for Hospital and medical costs related to an Injury. Any claim for accident benefits must be submitted no later than two years following the dismemberment.

DEATH BENEFITS: To receive Death Benefit payments, your Beneficiary or the executor of your estate must obtain a Death Benefit claim form from the Fund Office. Your Beneficiary must complete the claim form, attach a certified copy of the death certificate, and submit both to the Fund Office. Any claim for Death Benefits must be submitted no later than two years following the date of death.

ACCIDENT AND SICKNESS WEEKLY BENEFITS: To receive Accident and Sickness Weekly Benefits, obtain a disability claim form from the Fund Office. Complete your portion of the claim form and have your Physician complete the Physician's portion of the form. (If the Physician's portion of the claim form is not complete, payment will be delayed.) Mail the completed form to the Fund Office.

You do not need to file any further claim forms, even if you continue to receive benefits for several weeks of disability. The Fund Office will obtain the required information directly from your Physician. When benefit checks are issued to you, the Fund Office will request, from your Physician, continuing dates of disability and ask whether you remain under the Physician's care as required. Benefits then will be extended through the date of the Physician's signature or until:

- you no longer are under the Physician's care;
- you return to active employment; or
- the benefit is exhausted,

whichever occurs first.

CLAIMS APPEAL PROCEDURES

These claims appeals procedures apply to all self-funded benefits. The claims appeals procedures for insured benefits can be found in the insurance certificates referenced in Appendix B. To the extent the claims appeals procedures for the insured benefits do not meet Department of Labor requirements, the following claims appeals procedures will control.

Timing of initial claim denial (an "Adverse Benefit Determination"). If the Plan denies coverage for all or a portion of your claim, the denial is called an "adverse benefit determination," as defined under Department of Labor regulations.

When you submit a pre-service health care claim, the Plan will notify you whether the claim is approved within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of the Plan's receipt of the claim. If you fail to follow the Plan's procedures for filing a claim, you will be notified of the failure and the proper procedures as soon as possible, but no later than five days following the failure. The Plan will notify you verbally, unless you request the Plan to notify you in writing.

For organ transplants that are insured, the insurer will notify you directly of its decision. You must appeal directly to such insurance company according to its grievance procedures; the Fund Office will be glad to assist you. The decision by such insurance company will be final and binding.

For post-service health care claims, the Plan will notify you of an adverse benefit determination within a reasonable period of time, but not later than 30 days of the Plan's receipt of a claim.

For both pre- and post-service health care claims, if the Plan needs additional time to determine whether a claim is a covered expense for reasons beyond the Plan's control, the Plan may take one 15-day extension. The Plan will notify you prior to the expiration of the initial 15- or 30-day notification period, as applicable, of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If an extension is needed due to your failure to submit necessary information to decide the claim, the Plan, in the notice of extension, will specifically describe the required information needed. You have 45 days from receipt of the notice to respond to the request for information. The time period for the Plan to make its determination is suspended from the date on which the notice of the necessary information is sent to you until the date you respond. Once you respond, the Plan will decide the claim within the 15-day extension period. Your claim will be denied if you do not respond in a timely manner. The Plan may take only one extension for group health claims and may not further extend the time for making its decision unless you agree to a further extension.

A concurrent care health care claim is a claim that is reconsidered after the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and the reconsideration results in the reduction or termination of the treatment (other than by Plan amendment or termination) before the scheduled end of the treatment. If the Plan reduces or terminates treatment before the end of the course of the treatment, the Plan will notify you far enough in advance of the termination or reduction of treatment to allow you to appeal the adverse benefit determination and obtain a determination on review before the termination or reduction takes effect. The Plan must continue to cover the claimant for a concurrent care claim for ongoing treatment pending the outcome of an internal appeal.

For Accident and Sickness Weekly Benefit claims, the Plan has a reasonable period of time, not in excess of 45 days, to provide written notice of an adverse benefit determination. The Plan may extend the decision-making period for up to an additional 30 days for reasons beyond the Plan's control but the Plan will notify you in writing before the expiration of the 45-day period of the reason for the delay and when the decision will be made. A second 30-day extension is allowable if the Plan still is unable to make the decision for reasons beyond its control. You will be provided, before the expiration of the first 30-day extension period, a notice that details the reasons for the delay and the date as of which the Plan expects to render a decision. If an extension is needed because the Plan needs additional information from you, the extension notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and specify the additional information needed to resolve those issues. You will have 45 days from receipt of the notification to provide the requested information. The Plan will issue its decision within 30 days of the date you submit your information (subject to the 30-day extension previously described). Your claim will be denied if you do not submit the requested information in a timely manner.

For Death Benefit and Accidental Death and Dismemberment Benefit claims, the Plan has 90 days after receiving an initial claim to make its determination, unless additional information is required. In that case, the Plan will make its decision within 180 days after the claim has been received.

Rescissions of Coverage. An adverse benefit determination includes a rescission of your coverage under the Plan, except in the case of fraud or intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance only has a prospective effect. The following are not considered rescissions even though retroactive:

1. Retroactive termination to the extent attributable to failure to pay a timely premium (self-payment) towards coverage.

2. Retroactive elimination of coverage back to the date of termination of employment, due to delays in administrative recordkeeping if you do not pay any premiums for coverage after termination of employment.

3. The Plan's termination of coverage retroactive to the date of a divorce.

4. Any other retroactive termination as may be allowed under the Affordable Care Act.

This means that, in general, the Plan cannot terminate your coverage retroactively except under the circumstances previously described. The Plan will provide at least 30 days advance written notice to each Eligible Person who is affected by a rescission of coverage before the coverage may be rescinded.

Notice of Adverse Benefit Determination. If your claim for benefits is denied in whole or in part, the Administrative Manager will provide you, your Dependent, beneficiaries, or authorized or legal representatives, as may be appropriate (hereafter referred to as "you" or "your") with written or electronic notice of adverse benefit determinations within the time frames previously stated. Such notice will be provided in a culturally and linguistically appropriate manner. Notices will include the following information stated in an easily understandable manner:

Health Claims:

1. The specific reason or reasons for the adverse benefit determination.

2. References to specific Plan provision(s) on which the adverse benefit determination is based.

3. A description of any additional material or information, if any, necessary for you to perfect your claim and an explanation of why the material or information is necessary.

4. A description of the Plan's internal claims appeal procedures and time limits applicable to such appeal procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

5. Copies of any internal rule, guideline, protocol, standard, or similar criteria relied upon in making the adverse benefit determination or, a statement that such rule, guideline, protocol, standard, or other similar criteria was relied upon in making the adverse benefit determination and that a copy of such criteria is available free of charge upon request.

6. If the adverse benefit determination was based on a medical necessity or Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

7. If a medical or vocational expert's advice was obtained in behalf of the Plan in connection with your claim, you may request the identity of the expert, regardless of whether the advice was relied on.

Notices of adverse benefit determination for health claims *except* dental and vision claims will also include:

1. Information sufficient to identify the claim involved, including the date(s) of service; health care provider; claim amount; denial code and its corresponding meaning and diagnosis and treatment, and codes, including their corresponding meanings, upon request and without charge.

2. A statement that you have the right to request an external review with an Independent Review Organization (IRO) after the Plan's claims procedures have been exhausted.

3. The availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

Accident and Sickness Weekly Benefit Claims:

1. The specific reason or reasons for the adverse benefit determination, including a discussion of the decision, explaining the basis for disagreeing with or not following:

    a. The views presented by you to the Plan of any health care professionals who treated you or vocational professionals who evaluated you;

    b. The views of any medical or vocational experts whose advice was obtained by the Plan in connection with your claim; and

    c. A disability determination made by the Social Security Administration presented by you to the Plan.

2. References to specific Plan provision(s) on which the adverse benefit determination is based.

3. A description of any additional material or information, if any, necessary for you to perfect your claim and an explanation of why the material or information is necessary.

4. A description of the Plan's internal claims appeal procedures and time limits applicable to such appeal procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

5. Copies of any internal rule, guideline, protocol, standard, or similar criteria relied upon in making the adverse benefit determination, or a statement that such criteria does not exist.

6. If the adverse benefit determination was based on a medical necessity or Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgement of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

7. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Death and Accidental Death and Dismemberment Benefit Claims:

1. The specific reason or reasons for the adverse benefit determination.

2. References to specific Plan provision(s) on which the adverse benefit determination is based.

3. A description of any additional material or information, if any, necessary for you to perfect your claim and an explanation of why the material or information is necessary.

4. A description of the Plan's internal claims appeal procedures and time limits applicable to such appeal procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

The Plan will pay charges incurred for copies of medical records which have been requested by the Plan as necessary for processing a claim, whether it is determined that the Plan benefits are payable or denied.

If you feel that the action taken on your eligibility or claim is incorrect, you immediately should ask the Fund Office to review your claim with you. In some cases, the Fund Office may request additional information from you which might enable the Fund Office to reevaluate its decision.

Internal Claims Appeal Procedures

If all or part of a claim is denied or if you are otherwise dissatisfied with the determination made by the Plan, or if you have not received the notice of denial of your claim within the applicable time limits after the Plan has received all necessary claim information, you have the right to appeal the decision and request an internal review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

1. The Plan has three levels of appeal for health care claims (other than dental and vision) and two levels of appeal for all other claims. The first level of appeal is decided by the Eligibility and Appeals Committee of the Trustees. The second level is decided by the Executive Committee of the Board of Trustees. The optional third level is the Federal External Claims Review Process and is decided by an Independent Review Organization (IRO). The rules regarding claims appeal procedures apply to the first and second levels of appeal, while the optional Federal External Claims Review Process has its own independent appeal procedure.

2. **You will have 180 days after you receive the notice of an adverse benefit determination to file your appeal in writing to the Fund Office and it must include the specific reasons you feel denial was improper.**

3. You will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits which may have been requested in the notice of denial or which you may consider desirable or necessary.

4. You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to your claim for benefits.

5. The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, whether or not such information was submitted or considered in the initial benefit determination.

6. For health care claims, except dental and vision, and disability claims, the Plan will provide you, free of charge, any new or additional evidence considered, relied on, or generated in connection with an appeal or any new or additional rationale relied

upon in connection with the denial of an appeal and allow you to respond. Such information will be provided as soon as possible and sufficiently in advance of the date on which notice of the Plan's final adverse benefit determination must be provided in order to allow you a reasonable opportunity to respond prior to that date.

For health claims, except dental and vision, if the new or additional evidence is received so late that you will not have a reasonable opportunity to respond within the prescribed timeframe, the time period for the Plan to issue a decision will be pended until you have an opportunity to respond. The Plan will issue its decision on the appeal as soon as reasonably practical after you either respond or fail to respond.

7. The Plan will assign a decision maker on appealed claims that is an appropriate named fiduciary for the Plan and different than and not the subordinate of the person deciding the initial claim. The decision maker on appeal will not afford deference to the initial adverse benefit determination. The Plan will ensure that all claims and appeals are adjudicated with the utmost impartiality and avoid conflicts of interest. The claims or appeals adjudicator will be independent from and impartial to the Plan.

8. The Plan will consult with appropriate health care professionals in deciding appealed claims that are based in whole or in part on medical judgment, including determination of Experimental or investigational treatments and medical necessity. Such health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted for the appeal of an adverse benefit determination will be someone who was not consulted in the initial adverse benefit determination nor the subordinate of such individual.

9. If a medical or vocational expert's advice was obtained in behalf of the Plan in connection with your claim, you may request the identity of the expert, regardless of whether the advice was relied on.

10. For appeals of pre-service claims, the Plan will notify you of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of receiving the first appeal request and 15 days of receiving the second appeal request, if applicable.

11. For appeals of post-service claims, the Plan will notify you of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days of receiving the first appeal request and 30 days of receiving the second appeal request, if applicable.

12. For appeals of Accident and Sickness Weekly Benefit claims, the Plan will notify you of the decision within a reasonable period of time, but not later than 45 days after receiving the first appeal request and 45 days of receiving the second appeal request, if applicable.

13. The Plan will provide you with written or electronic notice of an adverse benefit determination within the time frames provided in this section. The notice will include the following information stated in an easily understandable manner:

Health Claims:

a. The specific reason or reasons for the adverse benefit determination including a discussion of the decision.

b. References to specific Plan provision(s) on which the adverse benefit determination is based.

c. A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

d. A statement describing any further appeal procedures offered by the Plan including your right to obtain information about such procedures.

e. A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's claims appeal procedures.

f. Copies of any internal rule, guideline, protocol, standard, or similar criteria relied upon in making the adverse benefit determination, or a statement that such rule, guideline, protocol, standard or other similar criteria will be provided free of charge to you upon request.

g. If the adverse benefit determination was based on a medical necessity or Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

The final notice of adverse benefit determination for health claims *except* dental and vision will also include:

a. Information sufficient to identify the claim involved, including the date(s) of service; health care provider; claim amount; denial code and its corresponding meaning and diagnosis and treatment codes, including their corresponding meanings, upon request and without charge.

b. A statement that you have the right to request an external review with an IRO after the Plan's claims procedures have been exhausted.

c. Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the external claims and appeals.

Accident and Sickness Weekly Benefit Claims:

a. The specific reason or reasons for the adverse benefit determination, including a discussion of the decision, explaining the basis for disagreeing with or not following:

   i. The views presented by you to the Plan of any health care professionals who treated you or vocational professionals who evaluated you;

   ii. The views of any medical or vocational experts whose advice was obtained by the Plan in connection with your claim; and

   iii. A disability determination made by the Social Security Administration presented by you to the Plan.

b. References to specific Plan provision(s) on which the adverse benefit determination is based.

c. A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

d. A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's claims appeal procedures and a description of the applicable contractual limitations period that applies to your right to bring a civil action under Section 502(a) of ERISA, including the calendar date on which such contractual limitations period expires.

e. Copies of any internal rule, guideline, protocol, standard, or similar criteria relied upon in making the adverse benefit determination or, a statement that such rule, guideline, protocol, standard, or criteria does not exist.

f. If the adverse benefit determination was based on a medical necessity or Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

Death and Accidental Death and Dismemberment Benefit Claims:

a. The specific reason or reasons for the adverse benefit determination.

b. References to specific Plan provision(s) on which the adverse benefit determination is based.

c. A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

d. A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's claims appeal procedures.

Federal External Claims Review Process – Rescissions and Health Claims Other than Dental and Vision Only

If the Plan has denied your health claim and issued you an adverse benefit determination under the internal claims appeal procedures, you may have the right to appeal your decision externally. Only health claims that involve medical judgment or a rescission of coverage are eligible for external review. Dental, vision, Accident and Sickness Weekly Benefit, death, and accidental death and dismemberment benefit claims are not eligible for external review.

The following procedures do not apply to the insured organ transplant benefit. External review rights for the organ transplant benefit are described in the insurance certificate.

Standard External Review

Request for External Review: You may file a request for an external review within four months after the date you received notice from the Plan of a final adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary Review: Within five business days following receipt of the external review request, the Plan will determine whether:

1. You are or were covered under the Plan at the time the health care service or item in question was requested, or in the case of a retrospective review, if you were covered under the Plan at the time the health care service or item was provided.

2. The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g. worker classification or similar determination) and does involve a medical judgment or rescission of coverage.

3. You have exhausted the Plan's internal claims appeal procedures, unless you are not required to do so under the appeals rules.

4. You have provided all the information and forms required to process an external review.

5. Within one business day of completing its preliminary review, the Plan will notify you in writing if:

    a. Your request is eligible for external review.

    b. If your request is complete, but you are not eligible for an external review, the Plan will provide you with the reasons it has determined that you are ineligible for an external review and the contact information for the Employee Benefits Security Administration (toll-free: 1-866-444-3272).

c. If your request is not complete, the notice will describe the missing information and materials needed to make the request complete. You may perfect your request if you do so within: the four-month filing period; or within 48 hours after the receipt of the notice, whichever date is later.

Referral to Independent Review Organization (IRO): The Plan has contracted with at least three IROs and rotates external review assignments among them (or incorporates other independent, unbiased methods for selection of IROs, such as random selection). The Plan will not provide the IRO with any financial incentives based on the likelihood that the IRO will support the denial of benefits.

If the Plan determines that your request is eligible for external review, your appeal will be assigned to an IRO. Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and reverse the Plan's adverse benefit determination. Within one business day after making such decision, the IRO will notify you and the Plan.

External Review Procedure

The assigned IRO will:

1. Timely notify you in writing of your request's eligibility and acceptance for external review.

   a. This notice will include a statement that you may submit additional information to the IRO for review. The additional information must be in writing and and received by the IRO within 10 business days following the date you received the notice. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

   b. If you submit any additional information, the IRO will forward the information to the Plan within one business day. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination. If the Plan decides to approve your appeal, the external review will be terminated. Within one business day after making such decision, the Plan will provide written notice of its decision to you and the assigned IRO.

2. Review all of the information and documents timely received. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching its decision:

   a. your medical records;

   b. the attending health care professional's recommendation;

   c. reports from appropriate health care professionals and other documents submitted by the Plan, you, and your treating provider;

d. the terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms unless the terms are inconsistent with applicable law;

e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

g. the opinion of the IRO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

3. Use legal experts where appropriate.

4. Review the claim de novo and not be bound by any prior decisions or conclusions reached during the Plan's internal claims and appeal process.

5. Provide written notice of its decision to you and the Plan within 45 days after the IRO received the request for the external review. The notice will contain:

a. a general description of the reason for the request for external review, including information sufficient to identify the claim [including the date(s) of service; the health care provider; the claim amount; the diagnosis and treatment codes and their corresponding meanings (if applicable); and the reason for the previous denial];

b. the date the IRO received the assignment to conduct the external review and the date of the IRO decision;

c. references to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision;

d. a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

e. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan;

f. a statement that judicial review may be available to you; and

g. current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

Reversal of Plan's Decision: If the IRO approves your external review, the Plan will provide coverage or payment for your claim immediately upon receipt of the prior notice.

Maintaining Records: The IRO will maintain all records of all claims and notices associated with the external review process for six years. You may review your records by contacting the IRO.

Binding Decision: The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under federal or state law. If the IRO approves your appeal, the Plan will provide benefits without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

Expedited External Review

Request for Expedited External Review: You may request an expedited external review at the time you receive:

1. An adverse benefit determination if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

2. A final internal adverse benefit determination if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or

3. A final internal adverse benefit determination if it concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency service, but you have not yet been discharged from a facility.

All requirements previously described for standard external review will apply, as modified by the following:

Preliminary Review: Immediately upon receipt of a request for an expedited external review, the Plan will determine whether the request meets the requirements on page 108. The Plan will then immediately send you written notice of whether the request is eligible for external review that meets the requirements described on pages 108 and 109.

Referral to Independent Review Organization: Upon determination that a request is eligible for external review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO as expeditiously as possible.

Notice of Final External Review Decision: The assigned IRO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the IRO will provide written confirmation of the decision to you and the Plan within 48 hours after the date of providing that notice.

The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner. You will be given maximum opportunity to present your viewpoint on any denied claim.

You may not begin any legal action, including proceedings before administrative agencies, until you have followed the procedures and exhausted the internal appeal opportunities described here. However, if the Plan fails to adhere to the procedures set forth in this section, you will be deemed to have exhausted the internal claims appeal procedures with respect to a claim and can seek external review or file a claim in court (unless the violation was de minimis, non-prejudicial, due to good cause or matters beyond the Plan's control, or in the context of an ongoing, good-faith exchange of information with you, and not reflective of a pattern or practice of non-compliance).

In the event that you request a written explanation of the violation, the Plan will provide an explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. For health claims, if the IRO or court rejects your request for immediate review, the Plan will provide you notice of the opportunity to resubmit and pursue the internal appeal of the claim. This notice will be sent within a reasonable time after the IRO or court rejects the claim for immediate review, but not later than 10 days. For Accident and Sickness Weekly Benefit claims, the claim will be considered refiled on appeal upon the Plan's receipt of the decision of the court rejecting your request for immediate review. The Plan will provide you with notice of the resubmission within a reasonable time after receipt of the decision of the court.

You may, at your own expense, have legal representation at any stage of these review procedures. No legal action for any benefits under the Plan may begin later than two years after the time the claim was required to be received by the Fund Office as specified on page 97. Benefits under this Plan will be paid only if the Board of Trustees (or its Administrative Manager) decides in its discretion that you are entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including but not limited to, its Administrative Manager). Such decision will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan.

If you have any questions about the claims appeal procedures described here, please contact the Fund Office.

YOUR RESPONSIBILITIES AS A PARTICIPANT UNDER THE PLAN

1. NOTIFY THE FUND OFFICE IMMEDIATELY REGARDING ANY CHANGE IN ADDRESS OR DESIRED CHANGE IN BENEFICIARY.

Most information about your Plan is sent to you by mail. For you to receive this information, we must have a correct address on file at the Fund Office at all times.

If you move, it is up to you to let us know your new address. Failure to do so may jeopardize your eligibility or benefits because we will have no way to contact you about any changes in the Eligibility Rules or changes in benefits.

The responsibility for advising the Fund Office of your new address is yours, and you must do so in writing.

2. NOTIFY THE FUND OFFICE OF A CHANGE IN MARITAL STATUS.

If your marital status changes or there are other changes which might affect the name of the person(s) you wish to designate as your Beneficiary, you must notify the Fund Office in writing regarding any change in Beneficiary you wish to make.

Once each year the Fund Office will mail you a "Family Information Form." You are required to update this form on a yearly basis.

3. NOTIFY THE FUND OFFICE WHEN YOU OR YOUR DEPENDENT HAS A CHANGE IN GROUP HEALTH COVERAGE.

You must inform the Fund Office if you or one of your Dependents has a change in coverage under another group health plan so this Plan can coordinate benefits properly.

4. MAKE SELF-PAYMENTS ON TIME AND IN THE CORRECT AMOUNTS.

Benefits paid by this Plan are financed primarily by Employer contributions based on the number of hours worked. However, the Plan also provides that if you are not employed or have not worked the required minimum number of hours to maintain eligibility, you may make up the difference with self-payments.

You will be notified if self-payments are required to maintain your eligibility. The self-pay notice indicates the amount due and the date due. Failure to pay the required amount on time will lead to a loss of eligibility.

The responsibility for making timely self-payments is yours.

5. NOTIFY THE FUND OFFICE IF YOU ARE WORKING OUTSIDE OF THIS FUND'S JURISDICTION.

Because of the nature of the construction industry, you may work in several different locations under the jurisdiction of several different trust funds during the year. So that you will not lose benefits as you change Employers, many trust funds have what is called a "reciprocity agreement."

Reciprocity means that when you work in the jurisdiction of another local (or Regional Council) and, therefore, in the jurisdiction of another fund, you may request that the contributions paid by your Employers to the other fund be transferred to this Fund (your home fund) and that the hours be credited to your account for determining eligibility. Transferring hours earned in the jurisdiction of another fund may reduce or cancel a self-payment you otherwise would have to make to maintain eligibility.

A list of trust funds that currently have reciprocity agreements with this Fund is available at the Fund Office. Your Local Union or Regional Council or the Fund Office also can tell you if the trust fund where you are working has a reciprocity agreement with this Fund and can provide you with the forms necessary to request a transfer of hours. You also may access the transfer form online: www.ncscbf.com.

In the event you work in some other Union's jurisdiction with which there presently is no reciprocity agreement, contact the Fund Office or your Union Office and efforts will be made to obtain a reciprocity agreement.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

STATEMENT OF PARTICIPANTS' RIGHTS UNDER ERISA

The Employee Retirement Income Security Act, commonly referred to as ERISA, sets forth certain minimum standards for the design and operation of privately-sponsored health care plans. The law also spells out certain rights and protections to which you are entitled as a Participant.

Trustees of the North Central States Regional Council of Carpenters' Health Fund want you to be fully aware of your rights, and for this reason, a statement of your rights follows.

As a Participant in the North Central States Regional Council of Carpenters' Health Fund:

1. You automatically will receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

2. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.

3. Each year you automatically will receive a summary of the Plan's latest annual financial report. A copy of the full report also is available upon written request.

4. You may examine, without charge, all documents relating to this Plan. These documents include: the legal Plan Document, insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports (Form 5500 Series) and Plan descriptions.

   Such documents may be examined at the Fund Office (or at other required locations such as worksites or Union halls) during normal business hours.

   In order to ensure that your request is handled promptly and that you are given the information you want, Trustees have adopted certain procedures which you should follow:

   a. Your request should be in writing.

   b. It should specify what materials you wish to look at.

   c. It should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

   Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any worksite or Union location at which 50 or more Participants report to work. Allow 10 days for delivery.

5. You can obtain copies of any Plan document governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description upon written request to Trustees, addressed to the Fund Office. ERISA provides that Trustees may make a reasonable charge for the actual cost of reproducing any document you request. However, you are entitled to know what the charge will be in advance. Contact the Fund Office to determine what the charge will be.

6. You have the right to continue health care 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.

7. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way or take any action which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

8. Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim.

   These procedures appear on pages 100 through 112 of this booklet. Basically, they provide that:

   a. If your claim for a health care benefit is denied, in whole or in part, you have a right to know why this was done. You will receive a written explanation of the reason(s) for the denial, and you have a right to obtain copies of documents relating to the decision without charge.

   b. Then, if you still are not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's claims appeal procedures.

   These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented in your behalf.

9. In addition to creating rights for Plan Participants, ERISA also defines the obligations of "fiduciaries," people involved in operating employee benefit plans. They have the duty to operate your Plan prudently and with reasonable care and to look out for the interests of Participants and Beneficiaries under the Plan.

10. Under ERISA, you may take certain actions to enforce the previously listed rights.

    a. If you request documents related to the Plan described in the prior 5, and do not receive them within 30 days, you may file suit in federal court.

       Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that: 1) the request was actually received;

2) the material was mailed to the right address; or 3) the failure to send the material was not due to circumstances beyond Trustees' control.

If you are unable to get the documents you requested, you may wish to take legal action. The court may require Trustees to provide the materials promptly or pay you a fine of up to $110 for each day's delay until you actually receive the materials (unless the delay was caused by reasons beyond Trustees' control).

b. Although Trustees will make every effort to settle any disputed claims with Participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

For this reason, you may file suit in a state or federal court if you feel you have been improperly denied a benefit. 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.

However, before exercising this right, you must take advantage of all the claims appeal procedures provided under the Plan at no cost. If you still are not satisfied, then you may wish to seek legal advice.

c. If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in federal court.

- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

- If you are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be expected to pay legal costs and fees.

We hope this booklet has provided you with the most important information about your Plan and your rights under ERISA.

If you have questions about your Plan, you should contact Trustees by writing to the Fund Office.

Or, if you have questions about this statement of your rights under ERISA or if you need assistance in obtaining documents from Trustees, you may contact the nearest office of the Employee Benefits Security Administration (EBSA) at U.S. Department of Labor listed in your telephone directory or at: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You also may find answers to your Plan questions, your rights and responsibilities under ERISA, and a list of EBSA field offices by contacting the EBSA by: calling 1-866-444-3272; sending electronic inquiries to www.askebsa.dol.gov; or visiting the website of the EBSA at www.dol.gov/agencies/ebsa/.

OTHER ERISA INFORMATION

PLAN NAME

The name of the Plan is the North Central States Regional Council of Carpenters' Health Fund.

THE NAME AND ADDRESS OF PLAN ADMINISTRATOR

The Plan is administered and maintained by the Board of Trustees. The Administrative Office of the Fund is located at:

THE BOARD OF TRUSTEES
North Central States Regional Council of Carpenters' Health Fund
1704 Devney Drive
Altoona, WI 54720
Mailing Address: P.O. Box 4002
Eau Claire, WI 54702

TYPE OF PLAN

The Plan is maintained for the exclusive benefit of the Employees and provides Death and Weekly Accident and Sickness Benefits for Employees and health care, vision, and dental benefits for Employees and Dependents. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PLAN SPONSOR AND NAMED FIDUCIARY

The Plan Sponsor and named fiduciary is the Board of Trustees of the North Central States Regional Council of Carpenters' Health Fund. This Fund is maintained by several Employers and one or more employee organizations, and is administered by a Joint Board of Trustees. A complete list of the Employers and employee organizations sponsoring the Plan may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and beneficiaries at the Fund Office.

PLAN ADMINISTRATION

Trustees hire and maintain an administrative staff under the direction and supervision of the Administrative Manager.

The Administrative Manager is responsible for carrying out Trustees' policy decisions, communications, recordkeeping, and accounting. Benefits are self-funded and Fund staff pays benefits subject to this Summary.

Any decisions of Trustees or the delegate of Trustees (including, but not limited to, the Administrative Manager) will be made in the sole and absolute discretion of Trustees or the delegate, as applicable, and will be final and binding upon all persons dealing with the Plan or claiming any benefit under the Plan, except to the extent the decision is determined to be arbitrary or capricious by a court having proper jurisdiction.

THE NAMES AND ADDRESSES OF TRUSTEES

Union Trustees

Corey Bialcik
North Central States Regional
Council of Carpenters
N2216 Bodde Road
Kaukauna, WI 54130

Chris Hill
North Central States Regional
Council of Carpenters
5238 Miller Trunk Highway
Hermantown, MN 55811

Burt Johnson
North Central States Regional
Council of Carpenters
700 Olive Street
St. Paul, MN 55130

Pat Nilsen
North Central States Regional
Council of Carpenters
10761 Virginia Plaza, Suite 100
Papillion, NE 68128

Wayne Nordin
North Central States Regional
Council of Carpenters
1190 West Laurence Road
Croquet, MN 55720

John Raines
North Central States Regional
Council of Carpenters
700 Olive Street
St. Paul, MN 55130

Pat Rodriguez
North Central States Regional
Council of Carpenters
2421 Larson Street
La Crosse, WI 54603

Chuck Spoehr
North Central States Regional
Council of Carpenters
N2216 Bodde Road
Kaukauna, WI 54130

Scott Watson
North Central States Regional
Council of Carpenters
5202 Monument Lane
Madison, WI 53704

Employer Trustees

Eric Ballweg
Vogel Brothers Building Company
P.O. Box 7696
Madison, WI 53707

Bob Barker
AGC of Wisconsin
4814 East Broadway
Madison, WI 53716

Sean Cullen
J.P. Cullen & Sons, Inc.
330 East Delavan Street
Janesville, WI 53547

Brad Deprez
IEI General Contractors, Inc.
P.O. Box 5067
DePere, WI 54115-5067

F. William Harvat
N6506 County Road W
Waupaca, WI 54981

Jeff McLean
J.H. Findorff & Son, Inc.
300 South Bedford Street
Madison, WI 53703

Sid Samuels
The Samuels Group
311 Financial Way, #300
Wausau, WI 54401

Jerry Shea
Market & Johnson
P.O. Box 630
Eau Claire, WI 54702

Dave Smestad
C.R. Meyer Company
P.O. Box 2157
Oshkosh, WI 54903

PARTIES TO THE COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to collective bargaining agreements.

Participating Labor Organizations

North Central States Regional Council of Carpenters
Carpenters Industrial Council

Carpenters Office Employees
Independent Union

Office and Professional Employees International Union

Participating Employer Groups

Associated General Contractors of Wisconsin, Inc.

Allied Construction Employers Association

And those Employers who are not members of or represented by such Association but which execute an individual collective bargaining agreement with the Local Unions.

The Union and Employer groups named here are parties to one of the several collective bargaining agreements requiring contributions be paid to this Trust Fund. A copy of any such agreement is available for examination by Participants and their beneficiaries at the Fund Office during normal business hours. Also, upon written request to the Administrative Manager, Participants and their beneficiaries may obtain:

1. a copy of any such agreement; and

2. information as to the address of a particular employer and whether that employer is required to pay contributions to the Plan.

INTERNAL REVENUE SERVICE EMPLOYER AND PLAN IDENTIFICATION NUMBERS

The Employer Identification Number (EIN) issued to the Board of Trustees is 39-6069788 and the Plan Number (PN) is 501.

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR SERVICE OF LEGAL PROCESS IS:

Nicole Falkner, Interim Administrative Manager
1704 Devney Drive
Altoona, WI 54720
Mailing Address: P.O. Box 4002, Eau Claire, WI 54702

Service of legal process also may be made upon any Plan Trustee.

SOURCES OF TRUST FUND INCOME

Sources of Trust Fund income include Employer contributions, self-payments, and investment earnings.

All Employer contributions are paid to the Trust Fund subject to provisions in:

1. the collective bargaining agreements between the Unions and Associations;

2. those Employers who are not members of or represented by such Associations but which execute an individual collective bargaining agreement with the Local Unions; and

3. Employers signatory to such labor contracts who cover their Non-Bargaining Unit Employees (NBU) under Trustees' NBU Participation Agreement or Alumni Participation Agreement. For Bargaining Unit Employees, labor agreements specify the amount of contribution, due date of Employer contributions, type of work for which contributions are payable, and the geographic area covered by the labor contract. For Non-Bargaining Unit Employees, Trustees determine the Employer contribution amount, due date, and related policies.

METHOD OF FUNDING BENEFITS

All benefits except organ transplant insurance and the CarePlus Dental option are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets are allocated for reserves to carry out the objectives of the Plan.

Associated Bank, Green Bay, Wisconsin, is the custodian of Fund assets. Monies not needed for immediate payment of benefits are invested by Baird Advisors, Blackrock, Invesco Advisors, and Northern Trust in accordance with guidelines established and monitored by Trustees.

Benefits for certain organ transplants as described on pages 34 through 36 are provided through an insurance policy with Tokio Marine HCC, 225 TownPark Drive NW, Suite 350, Kennesaw, GA 30144, 1-800-447-0460. Benefits eligible under the organ transplant insurance policy are submitted to and paid by Tokio Marine HCC.

Benefits for as the CarePlus Dental option described on page 48 are provided through CarePlus. Benefits eligible under this program are submitted by the provider directly to CarePlus and are paid by CarePlus directly to the participating provider.

PLAN YEAR AND FISCAL YEAR

The Plan Year and the Fiscal Year both begin January 1 and end the following December 31.

PROCEDURES TO BE FOLLOWED IN PRESENTING CLAIMS FOR BENEFITS UNDER THE PLAN

The procedures for filing for benefits are described on pages 97 through 99.

If a Participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are found on pages 100 through 112.

Benefits payable under the Plan are limited to Fund assets available, regardless of accumulated eligibility.

PLAN AMENDMENT AND TERMINATION

The Board of Trustees expects that the Plan will be permanent. However, the Trustees have the right and the authority, in their sole discretion, to modify, eliminate benefits, and methods of payments of benefits, amend any provision of the Plan, or terminate all or any part of the Plan whenever, in their sole discretion, conditions so warrant. If all or a part of the Plan is terminated, the Trustees would provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plan, and distribute the balance of the assets in a manner consistent with the purpose of the Fund. Plan amendments must be in writing and adopted by the Trustees. The Plan has no vested benefits, including retiree coverage.

ESSENTIAL HEALTH BENEFIT DEFINITION

The Affordable Care Act requires the Plan to adopt a benchmark plan to serve as a basis for the Plan's definition of essential health benefits. The Trustees have adopted the Utah state benchmark for this purpose.

Appendix A
HIPAA PRIVACY AND SECURITY

PRIVACY POLICY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to protect the confidentiality of your protected health information (PHI), including electronic PHI. The Plan's Privacy Practices Notice which follows sets forth your rights under HIPAA's privacy rules and regulations and the Plan's privacy policies and procedures.

HIPAA SECURITY REGULATIONS

The Plan has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of your PHI, including electronic PHI, that it creates, receives, maintains, or transmits. The Plan's agreements with its business associates will require that the electronic, physical, and technical security of electronic PHI be maintained.

DISCLOSURES TO PLAN SPONSOR (HIPAA Plan Amendment)

For purposes of this section, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. The Plan will use and disclose PHI in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to HIPAA, 45 C.F.R Parts 160 and 164 (the "Privacy Regulations") and security regulations, 45 C.F.R. Parts 160, 162, and 164 (the "Security Regulations"), which are incorporated by reference. The capitalized terms of art used herein are as defined by the Privacy Regulations and Security Regulations. The following provisions address disclosures of PHI to the Plan Sponsor for Plan administration purposes.

(a) Disclosures by Plan. The Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(b) Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(c) Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to individuals covered by the Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform the following Plan administration functions:

    (1) the Plan's Payment activities;

    (2) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan; and

(3) all of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

Uses and Disclosures of PHI by the Plan Sponsor

The Plan Sponsor will use and/or disclose PHI only to the extent necessary to perform Plan administration functions that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

Privacy Safeguards

The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law.

(b) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) Not use or disclose PHI for employment-related actions and decisions, unless authorized by the individual who is the subject of the PHI.

(d) Not use or disclose PHI in connection with any other Employee benefit plan, unless authorized by the individual who is the subject of the PHI or as permitted under the Privacy Regulations.

(e) Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the Plan.

(f) Make PHI available to an Eligible Person in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures.

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures.

(h) Make available the information required to provide an accounting of disclosures in accordance with the Plan's Privacy Regulations and the Plan's privacy policies and procedures.

(i) Make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations.

(j) If feasible, return or destroy all PHI that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Plan Sponsor. If return or destruction is not feasible, the Plan

Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained.

(k) Ensure that adequate separation between the Plan and the Plan Sponsor is established, described as follows.

Security Safeguards

The Plan and the Plan Sponsor will comply with the Security Regulations. The following provisions apply to electronic PHI that is created, received, maintained, or transmitted by the Plan Sponsor on behalf of the Plan, except for electronic PHI: (a) it receives pursuant to an appropriate authorization [as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)]; (b) that indicates whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan; or (c) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending, or terminating the Plan (as authorized under 45 C.F.R. section 164.508). The Security Regulations are incorporated herein by reference. The capitalized terms are defined by the Security Regulations.

The Plan Sponsor agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(b) Ensure an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures.

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI.

(d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Adequate Separation

The Plan Sponsor may use or disclose PHI only for Plan administration functions. The Plan Sponsor may not use or disclose PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan’s privacy policies and procedures or in violation of this Plan provision will be subject to the Plan’s privacy disciplinary procedure.

Limitations of PHI Access and Disclosure

The persons previously described only may have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan as described herein.

Noncompliance Issues

If the persons described herein do not comply with these privacy requirements, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Hybrid Entity

For purposes of complying with the HIPAA Privacy Regulations, this Plan is a Hybrid Entity because it has both health plan and non-health plan functions. The Plan designates that its health plan components that are covered by the Privacy Regulations include only health plan benefits and not other plan functions or benefits.

NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Health Information Technology for Economic and Clinical Health Act ("HITECH") and their Privacy Rules grant certain rights to Participants and beneficiaries of the North Central States Regional Council of Carpenters' Health Fund (the "Plan") in relation to their protected health information (called "medical information"). This Privacy Practices Notice discusses those rights and obligations.

The Plan may use and disclose your medical information without your permission for treatment, payment, and health care operations activities and, when required or authorized by law, for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

The Plan may disclose your medical information to your family members, friends, and others you involve in your health care or payment for your health care, and to appropriate public and private agencies in disaster relief situations.

IMPORTANT NOTE: The Plan reserves the right to provide your medical information to any person identified by you (such as a Business Agent), or whom the Plan in good faith believes was identified by you, or to a family member, other relative, or close personal friend. For example, the Plan may disclose your medical information to your Spouse if the Spouse contacts the Plan to help resolve a payment issue on your behalf. The Plan only will provide medical information in such a situation if it is directly relevant to such person's involvement with your care or payment related to your health care. If you object to such disclosures, please express your written objection to the contact person listed at the end of this notice.

The Plan may disclose to the sponsor of the Plan, the Board of Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Board of Trustees"), whether you are enrolled or disenrolled in the Plan, summary health information for certain limited purposes, and your medical information for the Board of Trustees to administer the Plan if the Board of Trustees explains the limitations on its use and disclosure of your medical information in the Plan Document.

Except for certain legally-approved uses and disclosures, the Plan otherwise will not use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures the Plan may make of your medical information, and to request that the Plan amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures the Plan may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

The Plan's Legal Duties

The Plan is required by applicable federal and state law to maintain the privacy of your medical information. The Plan also is required to give you this notice about its privacy practices, its legal duties, and your rights concerning your medical information. The Plan must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect September 23, 2016, and will remain in effect unless the Plan replaces it.

The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. The Plan reserves the right to make any change in its privacy practices and the new terms of its notice applicable to all medical information that the Plan maintains, including medical information the Plan created or received before the Plan made the change.

Uses and Disclosures of Your Medical Information

Treatment: The Plan may disclose your medical information, without your permission, to a Physician or other health care provider to treat you.

Payment: The Plan may use and disclose your medical information, without your permission, to pay claims from Physicians, Hospitals, and other health care providers for services delivered to you that are covered by the Plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the Participant of the Plan in which you participate and the like. The Plan may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: The Plan may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing, and credentialing activities;

- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- rating the risk and determining the necessary funding levels for the Plan, and obtaining stop-loss and similar reinsurance for the Plan's health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

The Plan may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give the Plan written authorization to use your medical information or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give the Plan a written authorization, the Plan will not use or disclose your medical information for any purpose other than those described in this notice. The Plan generally may not use or disclose any psychotherapy notes it holds only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: The Plan may disclose your medical information to a family member, friend, or any other person you involve in your health care or payment for your health care. The Plan will disclose only the medical information that is relevant to the person's involvement.

The Plan may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

The Plan will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relieve situation. In those situations, the Plan will use its professional judgement to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by the Plan at least 50 years after you die. After you die, the Plan may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told the Plan so.

Disclosures to the Board of Trustees: The Plan may disclose to the Board of Trustees whether you are enrolled or disenrolled in the Plan.

The Plan may disclose summary health information to the Board of Trustees to obtain premium bids for the health insurance coverage offered under the Plan or to decide whether to modify, amend, or terminate the Plan. Summary health information is aggregated claims history, claims expenses, or types of claims experienced by the enrollees in the Plan. Although summary

health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. The Plan is expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

The Plan may disclose your medical information and the medical information of others enrolled in the Plan to the Board of Trustees to administer the Plan. Before the Plan may do that, the Board of Trustees must amend the Plan Document to establish the limited uses and disclosures the Board of Trustees may make of your medical information. Please see the Plan Document for a full explanation of those limitations.

Health-Related Products and Services: The Plan may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits, and services that the Plan provides or includes, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in the Plan's network, if any, about replacement of or enhancements to the Plan, and about health-related products or services that are available only to the Plan's enrollees that add value to, although they are not part of, the Plan.

Public Health and Benefit Activities: The Plan may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect, or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state Worker's Compensation laws.

Individual Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to obtain access to your medical information. You should submit your request to the contact at the end of this notice.

The Plan may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact the Plan using the information at the end of this notice for information about these fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, the Plan will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, the Plan will produce it in a readable electronic form and format as the Plan and you mutually agree upon.

You may request that the Plan transmit your medical information directly to another person you designate. If so, the Plan will provide you the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where the Plan should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years, in which the Plan disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. The Plan will provide you with information about each accountable disclosure that the Plan made during the period for which you request the accounting, except the Plan is not obligated to account for a disclosure that occurred more than six years before the date of your request and never for a disclosure that occurred before the Plan's effective date (if the Plan was created less than six years ago).

Amendment: You have the right to request that the Plan amend your medical information. You should submit your request in writing to the contact at the end of this notice.

The Plan may deny your request only for certain reasons. If the Plan denies your request, the Plan will provide you a written explanation. If the Plan accepts your request, the Plan will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who the Plan knows may have relied on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that the Plan restrict its use or disclosure of your medical information for treatment, payment, or health care operations, or with family, friends, or others you identify. The Plan is not required to agree to your request, except for certain required restrictions described as follows. If the Plan does agree, the Plan will abide by the agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. Any agreement the Plan may make to a request for restriction must be in writing signed by a person authorized to bind the Plan to such an agreement. The Plan will agree to (and not terminate) a restriction request if:

- the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

- the medical information pertains solely to a health care item or service for which the individual, or person other than the Plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that the Plan communicate with you about your medical information in confidence by means or to locations that you specify.

You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request to the contact at the end of this notice.

The Plan will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit the Plan to collect contributions and pay claims. Please note that an explanation of benefits and other information that the Plan issues to the Participant about health care that you received for which you did not request confidential communications, or about health care received by the Participant or by others covered by the Plan, may contain sufficient information to reveal that you obtained health care for which the Plan paid, even though you requested that the Plan communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the Plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on the Plan's website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact the Plan using the information at the end of this notice to obtain this notice in written form.

State Law: As a condition of Plan participation, the Board of Trustees requires that the privacy rights of you, your Spouse, and Dependents be governed only by HIPAA and the laws of the State of Wisconsin (but only to the extent such laws are not preempted by the Employee Retirement Income Security Act of 1974, as applicable), without regard to whether HIPAA incorporates privacy rights granted under the laws of other states and without regard to Wisconsin's choice of law provisions.

Questions and Complaints

For more information about the Plan's privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact the Plan using the information at the end of this notice.

If you are concerned that the Plan may have violated your privacy rights, or you disagree with a decision the Plan made about access to your medical information, about amending your medical information, about restricting the Plan's use or disclosure of your medical information, or about how the Plan communicates with you about your medical information (including a breach notice communication), you may complain to the Plan using the contact information at the end of this notice.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

The Plan supports your right to the privacy of your medical information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Contact Information:	Privacy Official
Telephone:	(715) 835-3174, local 1-800-424-3405, toll-free
Address:	North Central States Regional Council of Carpenters' Health Fund P.O. Box 4002 Eau Claire, WI 54702

Appendix B
BENEFIT PROGRAM DOCUMENTS

The following Benefit Program Documents are incorporated into the Plan by reference. You will receive copies of the Benefit Program Documents applicable to your benefit:

- Organ & Tissue Transplant Certificate Policy
- CarePlus Total Access Dental Program Dental Care Group Policy Certificate of Insurance

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