

**NJ CARPENTERS HEALTH FUND**  
**Health Reimbursement Arrangement**  
**(Plan No. 501)**

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Express Scripts

**FISCAL YEAR (PLAN YEAR)  
Health Reimbursement Arrangement  
January 1 through December 31  
(Monthly Premiums)**

This document constitutes the entire plan document for the Health Reimbursement Arrangement (HRA) and the Summary Plan Description of the Health Reimbursement Arrangement. The Internal Revenue Service defines an HRA as a Health Reimbursement Arrangement; for the purpose of this SPD, HRA will also be used to refer to your individual account known as your Healthcare Reimbursement Account (HRA).

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

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

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

**“Benefits Watch”**

(Quarterly newsletter of the NJ Carpenters Funds)

**Website: [www.njcf.org](http://www.njcf.org)**

(Down-load printable version of the Plan)

Additionally, questions regarding the Plan can be directed to the Plan Administrator: George R. Laufenberg, New Jersey Carpenters Funds, Raritan Plaza II, P.O. Box 7818, Edison, NJ 08818-7818. Phone (732) 417-3900.

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

TO ALL ELIGIBLE EMPLOYEES:

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

Members are reminded that benefits under our NJ Carpenters Health Benefits Plan are determined by the NJ Carpenters Health Fund, not by Horizon Blue Cross Blue Shield of New Jersey. The same applies to a member's eligibility for benefits.

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

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

Sincerely yours,

THE TRUSTEES

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## INTRODUCTION

We are pleased to provide you with this booklet describing the benefits provided by the NJ Carpenters Health Fund (“NJCHF” or the “Fund”) for the Health Reimbursement Arrangement and your individual Healthcare Reimbursement Account. This booklet describes the benefits available to you as of January 1, 2013. The Board of Trustees reserves the right, in its sole discretion, to amend this booklet at any time. This document is referred to as your Summary Plan Description (“SPD” or “Plan”). This document is both the Plan Document and the Summary Plan Description of the benefits available from the Fund.

It is important that you understand how the plan works and we encourage you to read this document carefully. You should also share it with your Dependents so that they are aware of the benefits to which they may be entitled. Certain terms used in this booklet have specific meanings with respect to your benefits, please refer to the Definition section for an explanation of specific terms. The words “you” and “your” refer to the Participant unless the context clearly provides otherwise. Be sure to read all documentation you receive from the Fund. The Board of Trustees has the power to interpret, apply, construe and amend the provisions of the SPD and make factual determinations regarding its construction, interpretation and application, and any decisions made by the Board of Trustees, in good faith, are binding upon Contributing Employers, Participants, Dependents, and all other persons who may be involved with the Fund.

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

It is extremely important that you keep the Fund informed of any changes in your address, marital status or desired changes to your Beneficiary designation. This is your obligation and your benefits can be delayed if you fail to provide this information in a timely manner. Please remember that no one other than the Fund Office staff can verify your eligibility for benefits. You should not rely on statements regarding benefits made by your Employer, Union Agent, Shop Steward, Supervisor or other Participants. If you have trouble understanding any part of this material or have any questions about your benefits, contact the Fund office: Monday & Wednesday - 8:00 AM - 4:30 PM; Tuesday & Thursday - 8:00 AM – 6:00 PM, or Friday – 8:00AM – 4:00PM.

## **GENERAL INFORMATION**

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

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

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

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



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

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

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

## **OVERVIEW OF THE PLAN**

This SPD describes the benefits for certain eligible employees. Eligible employees include the following:

- (1.) NJ Shop Carpenters & Casino Maintenance Employees. A "Shop Employee" is a union carpenter employee who works for a signatory New Jersey shop affiliated with the Northeast Regional Council of Carpenters (NRCC) Local #252 under a Union Collective Bargaining Agreement requiring contributions to the Fund. A carpenter "Shop Employee" includes, but is not limited to, a cabinetmaker, assembler, laminator, utility worker and warehouseman. Also included are all others classified in shop and/or industrial contracts. A "Casino Maintenance Employee" is an "in-house" union carpenter employed at a New Jersey casino, including but not limited to, carpet and flooring mechanic, locksmith, gaming mechanic and upholsterer.
- (2.) Any other category of employees that the Trustees in their discretion choose to designate as eligible for participation in this Plan from time to time; provided that no employee may participate in this Plan unless he or she performs work for an employer signatory to a Collective Bargaining Agreement or other agreement requiring contributions to the Fund. The Trustees have complete discretion in determining which categories of employees are eligible and in determining the respective terms and conditions for participation in this Plan.

**If you have a question whether you are eligible to receive benefits from this HRA contact the Fund Office.**

Your Employer makes contributions to the Fund on your behalf. These contributions will be credited to a Healthcare Reimbursement Account (“HRA”). The amount your Employer is required to contribute on your behalf is based on the terms of its Collective Bargaining Agreement with the Union. For all purposes under the SPD, your HRA will be credited only with an amount equal to a percentage of the contributions actually received on your behalf, less administrative expenses. The Trustees have sole and exclusive discretion to determine the amount credited to your HRA.

**If your employer is delinquent in its contributions to the Fund or if contributions have not been transferred from a Reciprocal Welfare Fund on your behalf, you will not be credited with those contributions, for any purpose, until they are actually received by the Fund.**

Once you become eligible to seek reimbursement from your HRA, you must use your HRA contributions to pay the premiums for whichever level of health insurance you choose, (unless you opt-out of coverage by providing proof that you are currently enrolled in a plan providing “minimum essential coverage” as defined in the Internal Revenue Code). You can also use your HRA contributions to pay the cost of other Eligible Medical Expenses, which are described in Appendix A of this booklet.

**Pre-tax premiums paid by a spousal plan are not reimbursable through your HRA.**

The Fund offers a self-insured hospitalization, major medical and prescription drug benefit plan to you and your eligible dependents which are administered through the NJ Carpenters Health Fund. Options will include: Level 1 – Hospital/Surgical ONLY (Single or Family) and Level 2–Hospital/Surgical, Major Medical & Prescription (Single or Family). These options are described in more detail on pages 24-49.

All active members in the Plan will receive an Open Enrollment package which summarizes the options and premium rates available to you under the Plan.

**Once you elect your benefit program, it cannot be changed until the Fund’s next Open Enrollment Period, unless there is a qualifying event in which you are eligible to make a coverage change under the Special Enrollment Period.**

The Trustees have the discretion to make determinations regarding your HRA benefits, and all other self-insured benefits offered under the Plan. The Trustees also have the discretion to make determinations regarding eligibility for all benefits offered under the Plan. The Trustees have the right to change, or to reduce or eliminate the benefits provided to you and your Dependents.

# **YOUR HEALTHCARE REIMBURSEMENT ACCOUNT (HRA)**

## **HRA Main Features**

- Funded by collectively bargained, employer-based healthcare contributions.
- \$2000.00 Activation Balance.
- HRA balance above \$2,000.00 can be used for Eligible Medical Expenses.
- HRA balance at or below \$2000.00 can only be used for Primary Medical Premiums.
- Only Eligible Medical Expenses in Appendix A are reimbursable.
- Reimbursable expenses submitted monthly (Total \$100.00 minimum).
- Open Enrollment Period - Annually between November 15th – December 31st.
- Coverage Period January 1st – December 31st (payable monthly).
- Default Coverage for Active Members - Single Level 2.
- Coverage available:
  - Level 1 – Hospital/Surgical ONLY (Single or Family) or;
  - Level 2 - Major Medical, Prescription & Hospital/Surgical (Single or Family).
- Opt-Out- \$75.00 administrative fee: must submit Certificate of Creditable Coverage (see page 16).
- \$120.00 administrative fee: applies for accounts with no activity for a 12-month calendar period from January 1st – December 31st.
- 36-months of inactivity results in forfeiture of account (see page 19).
- Balance rolls over from year-to year.
- Retired Eligibility (see page 49).
- Disability Provision (see page 50).
- No Illness Credits.
- No cash payouts for HRA balance.
- No ownership of your individual account balance.
- HRA suspension if not available for work under the CBA.
- Must be an active or retired member, or eligible dependent, to submit claims.

## **How Your HRA Works**

Once contributions begin on your behalf, the Fund will establish an HRA in your name. An amount equal to all, or a percentage, of contributions received on your behalf will be credited to your HRA, (subject to deductions for administrative expenses). Once your initial HRA balance reaches \$2,000, your HRA can be activated and used for the payment of medical premiums and to reimburse you for Eligible Medical Expenses.

Only expenses included in Appendix A will be considered as reimbursable Eligible Medical Expenses. Once you become eligible you will be sent an enrollment packet and you will have 30 days to enroll.

**HRA's are funded by employer contributions and individual members have no ownership interest in their Healthcare Reimbursement Account balance.**

If your HRA balance is below \$2,000.00 it can only be used for the payment of primary medical insurance - NJCHF Level 1 or Level 2 premium, COBRA payments or, if opting-out, a spouse's post-tax healthcare premiums only. Premium payments for private insurance policies for vision or dental, or any approved eligible medical expense, will not be reimbursed if your HRA balance is below \$2,000.00.

If your Employer is delinquent in its contributions to the Fund, and as a result, you have an insufficient balance in your HRA to cover your medical premiums you must self-pay the required premium to the Fund in order to continue your medical and prescription drug coverage. If the Fund later recovers the delinquent amount owed from your Employer, you can submit a request to the Fund for reimbursement from your HRA of the premiums you self-paid as a result of the delinquency; provided your request for reimbursement is received within one year of the date self-payment is made.

**IF YOU ARE UNSURE IF A MEDICAL EXPENSE IS REIMBURSABLE, CONTACT THE FUND OFFICE PRIOR TO PAYING FOR THE EXPENSE.**

To be eligible for reimbursement, a claim form, available at the Fund Office or on the Fund's website, must be received by the Fund Office within 12 months of the date on which the expense was incurred. If a claim is received after the expiration of this 12 month period, your request for reimbursement will be denied. In general, the minimum allowable reimbursement is \$100. Therefore, expenses should not be submitted until, when added together, they total at least \$100. However, each January and July you may seek reimbursement of Eligible Medical Expenses that are less than \$100. In addition, you are limited to one submission of claims for each calendar month. However, you can submit as many claims as you want with each submission. For example, if you submit 6 claims for Eligible Medical Expenses on March 5, 2013, you are not entitled to submit claims again until April 1, 2013. If you submit a claim on March 21, 2013 instead of waiting until April 1, 2013, your claim will be denied as ineligible for reimbursement at that time, however, it will be reimbursable the following month based on the reimbursement rules. For all purposes, a claim is considered submitted to the Fund on the date it is received in the Fund Office.

Under no circumstances can you receive reimbursement for expenses that were incurred before the date you became a Participant in the Plan. All claims must be submitted in writing and include substantiated documentation satisfactory to the Fund that the expenses have been incurred and paid by you or your Dependent, and the amount of the charge. You must also confirm that the expenses have not been reimbursed and are not reimbursable under any other medical plan that provides health coverage. For doctor or hospital expenses or medical supplies, you must submit an Explanation of Benefits Statement from your primary insurance carrier or your doctor or hospital showing the expenses incurred and the balance owed. Please review Appendix A to determine exactly what documentation you are required to submit for each type of claim. If you are required to submit a receipt, such as from a doctor or pharmacy, you must submit the original receipt. **The Fund will not accept photocopied receipts.** In addition, the Fund will not return any documents to you. You should make copies for your records. Payments will be made directly to you or your Dependents, not to providers or suppliers.

### **SEE APPENDIX A FOR ELIGIBLE MEDICAL EXPENSES FOR REIMBURSEMENT**

If there is a balance in your HRA at the time of your death, your Dependents may continue to submit claims to the Fund for Eligible Medical Expenses they incur, provided that your dependent children satisfy the age requirements as described on page 22. However, if there are no reimbursements made from your HRA during any 36 month period following your death, your HRA will be forfeited consistent with the forfeiture rules described on page 19. Your Dependents can also use your HRA to pay for their continuing medical premiums under the Fund following your death. If there is an insufficient balance in your HRA to cover your medical premiums, your Dependents can continue their coverage at the active premium rate by self-paying their premiums directly to the Fund. Medical coverage will terminate once your Dependents do not self-pay their medical premiums, subject to the COBRA rules described on page 52.

The Fund has a right in its sole discretion to determine whether an expense is eligible for reimbursement from your HRA. A determination as to whether an expense is reimbursable will not be made until you have already paid for the supplies and/or services. As noted in Appendix A, certain expenses (e.g., durable medical equipment) require both a physician's prescription and a letter of medical necessity. The prescription must indicate the specific medical condition that the durable medical equipment is intended to treat. The letter of medical necessity must explain why the durable medical equipment is necessary and indicate the anticipated medical outcome. A letter of medical necessity is considered valid for

12 months from the date it is written by a physician, (unless the letter itself indicates that medical necessity will exist for fewer than 12 months). No Participant or Dependent can elect to receive cash or other taxable or non-taxable benefit from their HRA other than for the reimbursement of Eligible Medical Expenses.

You have no ownership interest in your HRA. The Fund has a right to deny your request for reimbursement from your HRA if the submitted expense is not permitted under the Plan.

**Suspension of Your HRA for Disqualifying Work** - Your Healthcare Reimbursement Account balance will be suspended if you engage in Disqualifying Employment. Disqualifying Employment means any month in which you: (1) are not available for work and refuse work under the Collective Bargaining Agreement, or (2) you work in any employment or self-employment for which no contributions are payable to the NJ Carpenters Health Fund on your behalf.

This definition of Disqualifying Employment applies whether work is performed for a Union or non-Union employer, whether or not the work is performed on a construction jobsite where carpenters covered under this Plan are employed, and includes supervisory, estimation, and project management work.

If you work in Disqualifying Employment, the following loss of benefits and rights apply:

1. Your Healthcare Reimbursement Account balance will be suspended;
2. Your ability to make self-payments to continue coverage will be lost; and
3. You may not use your HRA to pay COBRA premiums, however, you may be entitled to a COBRA election opportunity per the COBRA rules described herein.

## **ABOUT YOUR PARTICIPATION**

### **When Your Participation Begins**

You become a Participant in the Fund on the date your Employer begins making contributions to the Fund on your behalf. The Fund must receive a properly completed HRA Enrollment Form before you can begin receiving reimbursements from your HRA. Once \$2,000 in contributions have been received on your behalf, you are eligible to enroll yourself and your Dependents in health insurance coverage and seek reimbursement from your HRA for Eligible Medical Expenses.

The Fund will send you a Health Insurance Enrollment Application (“Health Insurance Application”) to begin your coverage, once \$2,000 in employer contributions have been received on your behalf. The Application will include a current Summary of Benefits with the amount of required monthly premiums for Level 1 and Level 2 (Single & Family) benefits.

Medical and prescription drug coverage, if applicable, for you and your properly enrolled Dependents will begin on the first day of the month following the date your properly completed Health Insurance Application is received by the Fund. However, you can start seeking reimbursement for Eligible Medical Expenses on the first day of the month following the date on which \$2,000 in Employer contributions have been received on your behalf.

Once you are enrolled in coverage, the Fund will automatically deduct the required monthly premium from your HRA. The Fund’s Board of Trustees have the right to change these premiums at any time. You will be notified of any such change.

**HRA Default Coverage** – If your Health Insurance Application is not completed and returned to the Fund Office within 45 days after it is sent to you, and you have an HRA balance greater than \$2,000.00, and you have not affirmatively opted-out of medical coverage, you will automatically be enrolled in: Single Level 2, for so long as your HRA is sufficient in amount to pay for the monthly premium.

**Opt-out of Coverage** - You can affirmatively opt-out of medical coverage by providing the Fund with sufficient proof that you have other medical coverage through a spouse’s plan, or Employer Sponsored Group Health Plan. You must submit proof of this alternative coverage annually by submitting a Certificate of Creditable Coverage. You will inform the Fund of your decision to opt-out of coverage by (1) requesting an enrollment form and checking off the “Opt-out” box on the application and (2) completing the Opt-out waiver form. If you opt-out of coverage, you cannot enroll in coverage until the next



Open Enrollment Period, unless you have a Special Enrollment Right, as described on page 51. Non-payment of a premium that causes a termination of alternative coverage is not a Special Enrollment Right.

**In any year you opt-out of coverage your HRA will incur a \$75.00 administrative fee. Opt-out years do not count towards NJCF Retired Eligibility rules, (as described in the NJCF Retired Plan SPD, a copy of which is available upon request to the Fund Office).**

## **ELIGIBILITY RULES**

### **Eligible Employee**

In order to become eligible for the provisions of this Health Plan, as an **Eligible Employee** you must;

- be available for work under a Collective Bargaining Agreement requiring contributions to this Fund;
- attain the \$2,000.00 activation balance for your HRA;
- have had employer contributions within a current 6-month period; and
- be a member in good standing with your Local Union.

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

## **IMPORTANT FORMS**

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

- 1. HRA Enrollment Form**
- 2. History Card**
- 3. Beneficiary Card**
- 4. Copy of Marriage Certificate**
- 5. Copy of Birth Certificates of spouse & eligible dependents**

**\*If forms 2-5 are already on file with NJCHF you do not have to resubmit.**

## Continuing Your Participation

Once you initially become eligible to receive benefits, you must maintain a \$2,000 balance in your HRA at all times to continue to be eligible to seek reimbursement from your HRA for Eligible Medical Expenses. If your HRA balance goes below \$2,000, your balance can only be used to pay for and maintain medical premiums, COBRA premiums, or post-tax medical premium payments associated with a spouses' health insurance. For example, if you have a \$2,500 balance in your HRA and submit claims for eligible medical reimbursements totaling \$1,000 for non-premium related expenses, the maximum amount you can receive is \$500.

Unless you become eligible for, and elect to receive retiree coverage (see page 49), or are eligible to continue your benefits because of a disability (see page 50), or are eligible for, and elect to receive COBRA coverage or USERRA coverage (see page 57) after you initially become eligible for Level 1 or Level 2 coverage, it will continue until one of the following occurs:

- The last day of the month during which there is an insufficient balance in your HRA to pay your premiums and you do not timely self-pay the difference to the Fund;
- the last day of the month in which you are no longer an Active Participant;
- your death;
- the date on which the Plan is terminated; or
- the date on which the Plan is amended to no longer provide coverage to you.

Once your coverage ends, you can re-qualify for benefit coverage once employer contributions begin again on your behalf and there is a total of at least \$2,000 in your HRA.

If, at any point in time, your HRA balance is not sufficient to cover your medical insurance premiums, you are eligible to self-pay the difference between your HRA balance and the amount of your required premiums directly to the Fund Office for a 12-month period in order to continue your benefit coverage, provided you are considered an Eligible Employee, (see page 17).

**Your self-pay premiums are due on the first day of the month for which this coverage is effective. If the Fund does not receive your premium by the 5th day of each month, your coverage for these benefits will terminate retroactive to the first day of that month (unless you are eligible for and timely elect to receive COBRA coverage). Once on COBRA, your coverage cannot be reinstated until you re-qualify for coverage.**

Payment is due on the first day of each month. You will receive an initial payment notice for the first month ONLY. You will not receive a payment notice from the Fund, thereafter. If you have any questions about the amount owed, it is your obligation to contact the Fund Office in advance of the date on which self-payment is due. Self-pay is not permitted if you are an owner/operator and your company is delinquent in contributions to this Fund or to the NJ Carpenters Pension, Annuity, or Apprenticeship Training Funds.

Your health coverage will not end solely because your Employer is not making contributions on your behalf if you are absent from Covered Employment due to your pregnancy, active military service, Family and Medical Leave (see page 57), or because you are receiving either State or Federal disability benefits or workers compensation benefits. However, if your HRA balance is not sufficient to cover your premiums, you will be required to self-pay the difference in order to maintain your coverage.

### **Administrative Fees**

Administrative Fees for Active Eligible Employees electing coverage through the NJCHF are included in the monthly premiums.

In any year you opt-out of coverage, your HRA will incur a \$75.00 administrative fee. Additionally, if there have been no contributions to, or withdrawals from your HRA during the 12-month period between January 1st and December 31st, the Fund will automatically deduct an administrative fee of \$120 from your HRA due to no activity. The date on which you have activity in your HRA (either an Employer begins making contributions again on your behalf or there is a withdrawal from your HRA), your account will be considered active.

Amounts deducted from contributions made to the Fund on your behalf or amounts deducted as an administrative fee will not be refunded to you even if contributions begin again at a later date. The Fund's Board of Trustees reserves the right to change these amounts at any time.

### **Forfeiture of HRA**

Any balance in your HRA will be forfeited following 36 consecutive months of no activity with respect to your HRA (no activity means that no Employer contributions have been made to your account and no amounts have been deducted from your account to pay premiums or claims for Eligible Medical Expenses). Forfeiture will occur on the last day of the 36th month. HRA balances will not be reinstated, even if your Employer again makes contributions to the Fund on your behalf at a later date. It is your responsibility to monitor the activity in your HRA. The Fund Office is not required to provide notice prior to any forfeiture.

## **HOW YOU CAN DO YOUR PART**

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

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

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

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

## **REPORTING CRITICAL EVENTS**

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

- **Change of address/telephone number**
- **Marriage or Divorce (must complete new beneficiary card)**
- **Addition or change in spouse's health coverage**
- **Addition or change in dependent children's health coverage**
- **Birth or adoption of a child**
- **Attainment of age 26 by dependent children**
- **Disability of employee or dependent**
- **Eligibility for Medicare/Medicaid of an employee or dependent**
- **Death of employee or dependent**
- **Change of beneficiary**
- **Eligibility for other health insurance**
- **Working in another jurisdiction**

A Notice of Change in Dependent Status Card must be completed and submitted to the Fund Office when any of these critical events occur. In addition, proof of dependency in the form of a marriage certificate, divorce decree or birth certificate/proof of parentage document is also required. No coverage will be afforded to any dependents unless all proper documentation is received. Once the proper documentation is received, your eligible dependents will be enrolled the first day of the following month. (Subject to applicable Special Enrollment Rights described on Page 51).

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

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

## **WORKING SPOUSE POLICY**

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

### Highlights of the Working Spouse Policy:

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

- NJ Carpenters Health Fund will provide secondary coverage for a spouse covered by their employer's plan, (if currently enrolled in NJCF Level 1 or Level 2 Family coverage).
- NJ Carpenters Health Fund will provide primary coverage for a spouse who has no other coverage or is not working, (if currently enrolled in NJCF Level 1 or Level 2 Family coverage).
- A working spouse who is eligible for health coverage through their employer, but has missed the open enrollment election period, must enroll at the next available opportunity.
- Any spouse who does not comply by refusing to enroll, or those who fail to return the form, will have their coverage suspended until such form is returned.
- Policy applies to both Medical and Prescription Drug Coverage. A spouse is not required to enroll in a Dental or Vision program.

## **Dependent Participation**

Your eligible Dependents will be eligible for benefits under the Plan on the same day your participation begins, provided you choose family coverage, and their participation will continue for as long as you remain a Participant and they remain eligible Dependents. You may be required to provide periodic proof that your Dependents continue to meet the requirements for coverage. Your eligible Dependents include your lawful spouse and your children, as defined below:

- 1. Eligible Lawful Spouse** is the person to whom you are legally married under the laws of the State in which you reside. If you are legally divorced, your ex-spouse is not eligible for coverage under the Plan. Coverage for a new spouse becomes effective the first day of the month following the date of your marriage, provided a valid marriage certificate is submitted to the Fund Office within 30 days. Divorced spouses, including those who are divorced from bed and board, are covered until the effective date of your divorce decree or other applicable court order. It is the member's responsibility to notify the Fund Office and provide us with a copy of the divorce decree or other applicable court order.
- 2. Eligible Child** is your biological child, stepchild, adopted child, a child placed with you in anticipation of adoption or your legal guardianship. A child is generally eligible for coverage until the last day of the month in which the child attains age 26.

Your Dependents will receive the same hospital, medical and prescription drug coverage as you, provided family coverage is elected. In addition,

you are eligible to seek reimbursement from your HRA to cover Eligible Medical Expenses incurred by your Dependents, but only for your Dependents that are included on your HRA Enrollment Form. Unless your Dependent has a Special Enrollment Right, (see page 51), a Dependent can only be enrolled in the HRA program during each Open Enrollment Period. If your Dependent is enrolled in the HRA but does not enroll in Level 1 or Level 2 coverage, or does not prove that he has alternative health insurance coverage, such Dependent will automatically be enrolled in the same level of medical coverage in which you are enrolled and you would be required to pay the Family coverage cost.

To be considered a Dependent, your spouse and/or child must be a citizen, national or resident of the United States, except that an adopted child may still be considered a Dependent if the child has the same principal residence as the Participant and the Participant is a citizen, national or resident of the United States.

**Enrolling Dependents in NJCHF Level 1 or Level 2 Coverage** – You can enroll your Dependents in Fund coverage at the same time you become eligible for benefits by including them on your HRA Enrollment Form. If you do not enroll your Dependents in the Fund when they first become eligible for coverage, you cannot enroll them in the Fund for any benefits until the next Open Enrollment Period, unless they become eligible for Special Enrollment (see page 51).

### **When Dependent Participation Ends**

Dependent coverage ends when your coverage ends or earlier if a Dependent no longer satisfies the eligibility requirements for being a Dependent.

- Your spouse's coverage ends on the date your divorce is finalized.
- Your child's coverage ends on the last day of the month during which your child reaches the age of 26.

**Qualified Medical Child Support Orders** – A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or State administrative agency that requires that medical coverage be provided under a plan for a child or children. A QMCSO usually results from a divorce, legal separation or paternity proceeding. The Fund Office will notify you if a QMCSO is received with regard to your coverage. If you, your child, or the child's custodial parent or legal guardian would like a copy of the Plan's written procedures for handling QMCSOs, or if you have any questions about this process, please contact the Fund Office.

# YOUR HEALTHCARE BENEFITS BENEFIT COVERAGE SUMMARY LEVEL 1

**For Eligible Active Employees:**

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

Loss of:

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

Loss of:

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

**For Eligible Active Employees and Dependents:**

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

**Emergency Room Services - \$100.00 co-pay. (Waived if admitted)**

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

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

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

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



# YOUR HEALTHCARE BENEFITS

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

**If you have any questions regarding your health benefits, contact the Fund Office.**

## LEVEL 1 BENEFITS – HOSPITAL / SURGICAL

### PRE-CERTIFICATION PROGRAM

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

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

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

Remember, it is your responsibility to make sure your medical provider contacts the appropriate number on the back of your medical identification card to pre-certify your admission.

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

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

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

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

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

## **CASE MANAGEMENT PROGRAM / UTILIZATION**

**Case Management** – This program assures quality medical care that is cost effective to you and the Fund. Individual case management may be provided for those members/dependents that have been identified as having an illness or injury that may require extensive medical care or guidance through the health care delivery system. The case management program monitors the utilization of hospital admissions, discharge planning services, rehabilitation therapy, and other healthcare services that require pre-authorization.

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

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

## HOSPITAL BENEFITS

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

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

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

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

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

**\$100.00 co-payment applies, waived if admitted.**

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

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

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

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

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

## **SURGICENTER BENEFITS**

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

## **BEHAVIORAL HEALTH BENEFITS (Mental Health & Substance Abuse)**

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

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

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

## **MEDICAL-SURGICAL BENEFITS**

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

### **FEE SCHEDULE**

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

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

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

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

### **Contact the Fund Office:**

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

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

### **IN-HOSPITAL MEDICAL CARE**

- **Days Available** - You are entitled to one physician visit per day to render medical (non-surgical) care.
- **Concurrent Medical Care** - Benefits are provided for concurrent medical care visits by other physicians to a hospital inpatient for multiple diagnoses when it is medically appropriate due to the nature or severity of the covered person's condition. However, the medical care must not be considered normal pre-operative or post-operative care.

- Consultations – You may receive benefits for one inpatient consultation by a specialist during each eligible inpatient hospital stay provided the consultation is requested by your attending physician in connection with a diagnosed condition. If your condition involves a number of different specialties, each specialist's initial consultation will be eligible for reimbursement.

**SURGICAL CARE** – Benefits are provided up to our fee schedule for operative or surgical cutting procedures, the reduction of fractures and dislocations, and for endoscopic and other surgical-diagnostic procedures wherever performed by your physician. Participating physicians accept our payment as payment in full. If services are rendered by a non-participating provider, you will be responsible for the difference between 100% of our fee schedule and the provider's charges.

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

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

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

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

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

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

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

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

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

- Hospital and medical services for any condition related to pregnancy including childbirth, newborn care, abortion or miscarriage, are covered for enrolled female employees or for the enrolled spouse of any employee. Obstetrical care is not available to dependent children.
- The Fund Office considers newborn care to be all services provided within the first 30 days of the newborn's life, unless the newborn continues to be hospitalized exceeding 30 days.
- **High Risk Pregnancy** – Contact the Case Management Department at the Fund Office if you are considered a high-risk pregnancy. There are specialty high-risk Case Managers available to guide you through your pregnancy.
- **Birthing Center Benefits** – As an alternative to conventional hospital delivery room care, a person eligible for maternity benefits may elect to receive maternity care from an approved birthing center where services may be rendered by a licensed certified nurse-midwife. The nurse case managers must be contacted prior to the use of a birthing center. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of a newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours for cesarean section). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours for cesarean section).

## **DIAGNOSTIC X-RAY & LABORATORY EXAMINATIONS**

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

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

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

## **WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998**

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

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

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



## **MASTECTOMY & PROSTHESIS**

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

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

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

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

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

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

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

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

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

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

Medical-Surgical and or Major Medical/Co-Pay Benefits (as appropriate) are provided for oral surgical services such as surgical treatment of malignancy of the mouth, treatment of jaw fractures and dislocations, removal of tumors of the mouth or jaw, accidental injury to the mouth, operative and cutting procedures for treatment of diseases and injuries of the jaw. These services are available when performed in the outpatient department of a hospital or in a physician's office. However, these services are covered for an inpatient stay only if the hospitalization is required because the patient has a serious medical condition that would make such services hazardous if rendered elsewhere. Benefits are provided for the services of your dentist for the removal of impacted wisdom teeth when performed in the doctor's office. The impacted wisdom teeth must be verifiable by X-rays. If the removal requires hospitalization on an inpatient or outpatient basis, the admission must be pre-approved by the Fund Office. No benefits are provided for other extractions or any dental services involving care of teeth, gingival tissue or alveolar processes.

### **ORGAN/BONE MARROW TRANSPLANTS**

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

## **BENEFIT COVERAGE SUMMARY LEVEL 2**

### **For Eligible Active Employees and Dependents:**

Same benefits as shown for Level 1 coverage, plus:

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

**\$10.00 co-pay for all office visits, except those exclusively for preventive services, as defined in the Affordable Care Act.**

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

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

**Behavioral Health Benefits** – \$10.00 co-pay for psychotherapy and medication management. There is a Managed Care Program in effect for this benefit. Contact the Fund Office for participating providers.

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

- **Retail Pharmacy: (30-day supply)**  
Generic Drugs: \$5.00 co-payment  
Brand Name Drugs: 20% co-payment when no generic available
- **Mail Order Drug Program: (90-day supply)**  
Generic Drugs: \$10.00 co-payment  
Brand Name Drugs: 20% co-payment when no generic available

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

<b>THIS IS ONLY AN OVERVIEW OF YOUR LEVEL 2 HEALTH BENEFITS.</b>
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## **LEVEL 2 BENEFITS – MAJOR MEDICAL / PRESCRIPTIONS**

**Co-payment – \$10.00 co-payment for all office visits, except those exclusively for preventive services, when using participating providers. Contact the Fund Office for participating providers or log onto: [www.njcf.org](http://www.njcf.org).**

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

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

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

The following services are Eligible Major Medical Expenses:

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

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

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

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

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

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

**Skilled Nursing Care** – You must contact the Fund Office for pre-approval for skilled nursing care. Based upon medical necessity, the Fund Office will arrange to have a Registered Nurse or Licensed Practical Nurse (not a Home Health Aide) come to your home to render services. A physician's order does not guarantee reimbursement. New Jersey Carpenters Health Fund will not pay for custodial care, private-duty nursing, or the services of a Home Health Aide.

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

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

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

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

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

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

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

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

**Chiropractic Benefit** – The chiropractic benefit is limited to \$1,200.00 per covered family per benefit year. Eligible charges, including X-rays, are payable at 80% of our fee schedule after the Annual Family Deductible has been met. There is a participating chiropractic network. If you use a

participating chiropractor, there is no deductible or co-pay. All services must be provided by a licensed Doctor of Chiropractics (D.C.). All eligible services that are approved will be counted toward the \$1,200.00 annual family maximum.

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

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

**Behavioral Health** – There is a \$10.00 co-pay for psychotherapy and medication management. To minimize your out-of-pocket-expense, contact the Fund Office or search the web-site at **[www.njcf.org](http://www.njcf.org)** for participating providers. Pre-approval is needed for all treatment with a participating provider. Psychotherapy is covered when provided by a licensed mental health professional including, but not limited to, licensed psychiatrist, psychologist, social worker, licensed professional counselor, and clinical nurse specialist supervised by a psychiatrist. Benefits are also provided, up to our fee schedule, for psychotherapy services received in the outpatient department of a hospital. Contact the Behavioral Health Department at (732) 417-0300.

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

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

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

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

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

## **MOTORCYCLE / RECREATIONAL VEHICLE ACCIDENTS**

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

## **PRESCRIPTION DRUG PROGRAMS**

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

**The following prescriptions are not covered:**

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



**Call the Fund Office for additional exclusions.**

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

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

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

- **Brand Name Drugs:** 20% co-payment for a 30-day supply when there is no generic available.
- **Generic Drugs:** \$5.00 for up to a 30-day supply.
- **Specialty and/or Injectable Drugs:** 20% co-payment.
- **Certain preventive prescription drugs have \$0 co-pays as mandated by the Affordable Care Act.**

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

- **Brand Name Drugs:** 20% co-payment for a 90-day supply when there is no generic available.
- **Generic Drugs:** \$10.00 for a 90-day supply.
- **Specialty and/or Injectable Drugs:** 20% co-payment.
- **Certain preventive prescription drugs have \$0 co-pays as mandated by the Affordable Care Act.**

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

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

*Express Scripts* order forms may be obtained at [www.express-scripts.com](http://www.express-scripts.com) or by contacting the Fund Office at 1-800-624-3096.

### **Prilosec OTC Program (PPI Class of Drugs)**

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

### **Express Scripts Claim Forms (formerly Medco)**

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

## **NJCHF Level 1 & Level 2 Limitations**

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

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

2. In regards to injuries suffered in either a motorcycle or recreational vehicle accident, only Level 1 benefits (excluding services provided by acute, sub-acute, or skilled nursing rehabilitation facilities) will be eligible for coverage under the New Jersey Carpenters Health Plan. No Major Medical/Co-Pay benefits will be eligible for reimbursement (i.e. follow-up office visits, physical therapy, acute or sub-acute rehabilitation facilities, prescription drugs, durable medical equipment).

3. Costs for services obtained at a non-participating hospital will be limited to the amount the Health Fund would have paid to a hospital located in our participating network.

## NJCHF LEVEL 1 & LEVEL 2 EXCLUSIONS

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

1. Services eligible for payment under any other insurance. (i.e. Medicare, auto insurance, homeowners insurance or worker's compensation, etc.).
2. Services or supplies that are not considered medically necessary for your diagnosis and treatment.
3. The non-availability of other facilities will not be considered a valid reason for admitting a covered person to a higher level of care than is medically required for their condition.
4. Services you would not have a legal obligation to pay in the absence of this or any other insurance coverage.
5. Consultations required by hospital regulations which are not medically necessary for the disease entity or for stand-by services provided by hospital personnel.
6. Procedures, treatments, drugs, services or supplies that are not approved or are considered of a research nature by the Food and Drug Administration or the American Medical Association for the diagnosis.
7. Services or supplies that are received from a dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or any similar person or group.
8. Claims that are not submitted within one year (12 months) following the date of service. Appeals that are not submitted within one year (12 months) from the date the claim was processed.
9. Services to anyone who is on active military duty. (Subject to applicable rights under USERRA.)
10. Experimental, educational, investigational or ineffective procedures or treatments. Subject to the terms of Public Health Service Act 2709 and effective January 1, 2014, the routine patient costs for items and services furnished in connection with participation in an approved clinical trial are covered by the Plan. See discussion of experimental services on page 87 for a full description of clinical trial coverage.

11. Services made necessary by a disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
12. Services rendered or supplies provided prior to the covered person's effective date or after coverage is ended, for any reason unless specifically provided for in this booklet.
13. Charges which are in excess of our fee schedule.
14. Charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim or medical history form.
15. Personal services such as, but not limited to, haircuts, shampoos and sets, guest meals and radio/telephone/television/VCR/DVD/ tape rentals.
16. Durable medical equipment and personal convenience items which are primarily for comfort and convenience rather than a medical purpose, including but not limited to: air conditioners, humidifiers, purifiers, physical fitness equipment, heating pads, jacuzzis, whirlpools, tanning beds and similar supplies which are useful to a person in the absence of illness or injury.
17. Charges incurred during a covered person's temporary absence from the eligible provider's facility before discharge.
18. Services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable State laws or regulations.
19. Dietary or nutritional counseling for behavior modification classes or weight loss programs or food supplements (i.e. *Optifast*, *Nutrisystem*, *Weight Watchers*, etc.), unless categorized as preventive in nature by the U.S. Preventive Services Task Force established by the Patient Protection and Affordable Care Act.
20. Services for treatment of obesity unless the criteria for gastric bypass/lapband surgery is met.
21. Routine or periodic physical examinations, testing and immunizations which by law are required for employment. This includes immunizations required for traveling outside of the United States.
22. Charges for services or supplies which any school system or township is required to provide under any law or guidelines, or charges or supplies which any school system or township provides on a discretionary basis upon application or, other form or request by a participant or their dependent.

23. Any charges for services relating to learning disabilities, including psychological and neuropsychological testing.
24. Travel, whether or not recommended by a physician.
25. Surgery and any related services or supplies intended solely to improve appearance.
26. Repair of complications resulting from plastic or cosmetic surgery or from medications which were not medically necessary.
27. Treatment of sexual dysfunction, including but not limited to, erectile dysfunction and insertion of penile implants and pumps.
28. Treatment leading to or in connection with transsexual surgery, including prescription drugs.
29. Fertility treatments and associated prescription drugs including all surgical procedures and testing, including but not limited to, ovarian transplants, in vitro fertilization, zift, gift, and any assisted reproductive technology (ART).
30. Any claims pertaining to surrogate pregnancy, including delivery or any complications arising thereof.
31. Reversal of sterilization procedures under any circumstance.
32. Services & supplies for any condition related to the pregnancy of a dependent child.
33. Care in nursing home or home for the aged.
34. Custodial care such as sitters, homemaker's service, home health aide or care in a place that serves you primarily as a residence.
35. Services or supplies in connection with any procedure or examination not incident to or necessary for diagnosis of any injury or sickness for which bonafide provisional diagnosis has been made because of existing symptoms.
36. Services or supplies not listed as Eligible Medical Expenses.
37. Convalescent, custodial or sanitorium care or rest cures.
38. Exercise programs for treatment of any condition, including membership fees for fitness centers (i.e. Health Spas, YMCA, etc.).

39. Any claims incurred as a result of the commission of a crime (i.e. Driving While Intoxicated or Voluntary Illegal Drug Use, etc.) but not excluding claims incurred as a result of a crime of domestic violence.
40. Any claims incurred while in the custody of the State or local justice system.
41. Treatment for injuries sustained while engaged in unlawful conduct but not excluding injuries related to crime of domestic violence.
42. Any charges for services that are mandated by the courts, schools, or State, including but not limited to, marriage counseling, custody mediation, or mental health/substance abuse evaluation or treatment. Alcohol/drug rehabilitation to avoid or reduce jail time is not eligible.
43. Services provided during any part of a stay at a hospital, detoxification facility or residential facility chiefly for bed rest, rest cure, convalescent, custodial or sanitorium care or diet therapy.
44. Long term residential substance abuse or psychiatric admissions, or partial care or day treatment programs.
45. Services during a hospital stay or any period of a hospital stay which is primarily for diagnosis studies or examinations, unless the nature of the diagnostic procedure or the patient's physical condition is such that hospitalization is medically necessary.
46. All comprehensive treatment programs related to Pervasive Developmental Disorders, such as applied behavioral analysis and similar treatments.
47. Auditory Processing evaluations are excluded in the absence of an acute illness or injury.
48. Your prescription drug co-payments are not reimbursable.
49. Vitamins and other medications available over-the-counter.
50. Biofeedback regardless of diagnosis.
51. Hypnotherapy regardless of diagnosis.
52. Services provided by an occupational therapist in the absence of an acute illness or injury.

53. Care and treatment for hair loss including wigs, hair transplants or any drug that promotes hair growth, with the exception of hair loss due to chemotherapy treatment.
54. Charges incurred when the patient is non-compliant with provider's plan of care.
55. Work hardening programs, including but not limited to, Functional Capacity Evaluations (F.C.E.).
56. Chiropractic care and physical therapy administered on the same day.
57. Prescriptions while at a residential facility, including nursing homes and assisted living facilities, in which your medications are not self-administered.
58. Treatment or care in a residential facility or halfway house for mental health or substance abuse.
59. Drug testing (urine or blood tests) except when included as part of a structured behavioral treatment program ie: intensive outpatient program, partial hospitalization program.
60. Charges for hospital based pathologist billing for calibrating or maintaining hospital laboratory equipment.
61. Manipulation Under Anesthesia (MUA) is not a covered benefit unless specified.
62. Cognitive therapy in the absence of an acute illness or injury.
63. Autologous blood collection, processing and storage.
64. Non-FDA approved services, drugs, devices, treatments, products, including blood products, or therapies.
65. Infant formula is not a covered benefit. However, any infant formula requiring a prescription must be submitted to the Fund Office for review and determination of benefits.
66. Enteral nutritional feeding is covered only when through tube feeding and is the only source of nutrition.
67. Glucose Sensors associated with an insulin pump.



68. Private-duty nursing, regardless of where services are rendered.
69. Vision therapy, including but not limited to, visual therapy, pleoptic training, vision training, optometric vision therapy, orthoptics, neuro-optometric rehabilitation, behavioral optometry, and developmental optometry.
70. Lasik eye surgery, regardless of diagnosis.
71. Routine vision services, including but not limited to, eye examinations, lenses, frames, and contact lenses.
72. Dental services involving care of teeth, except as specified under our medical benefits.
73. Orthodontic and periodontic services and treatments.
74. Hearing aid appliances, repairs to the hearing aid appliance or the purchase of batteries.

### **Retired Eligibility**

A retired individual qualifies for benefits and is an Eligible Retired Participant under the NJ Carpenters Retired Health Plan if all of the eligibility conditions listed in the NJ Carpenters Retired Health Plan Summary Plan Description (SPD) are satisfied. Contact the Fund Office for a copy of the NJCF Retired Health Plan SPD.

**Determining Years of Active Coverage** - In addition to the requirements in the NJ Carpenters Retired Health Plan (SPD), HRA participants will have their "Years of Active Coverage" determined as follows. Any Years of Active Coverage earned prior to January 1, 2013, will be combined with your Years of Active Coverage under the HRA for the purpose of determining your Years of Active Coverage. For participants whose first year of service began prior to April 1, 2011, your combined Years of Active Coverage must total a minimum of 25 years. For participants whose first year of service began on or after April 1, 2011, your combined Years of Active Coverage must total 30 years.

**Any year in which you decide to OPT-OUT of NJCHF  
Level 1 or Level 2 coverage will NOT count towards your  
"Years of Active Coverage" requirement.**

## Disability Provision

If a Participant is receiving permanent Social Security disability benefits, participation in the Plan will continue for as long as the Participant is receiving such disability benefits, (up to age 65), provided the Participant meets the eligibility requirements listed below and pays the current HRA premiums for hospital/surgical, medical, and prescription drug coverage, either from his HRA or through direct self-pay. Upon becoming Medicare eligible, you may continue to purchase NJCHF Level 1 or Level 2 coverage at the actual cost; however, coverage will be secondary for the disabled member and primary for eligible dependents, all eligibility rules apply. Contact the Fund Office for more information.

Eligible participants may also continue to submit claims for the reimbursement of Eligible Medical Expenses, provided your HRA balance does not go below \$2,000.

In order to be eligible to pay for the health insurance offered by this plan as a disabled participant, all of the following conditions must be satisfied:

1. **Social Security Award Letter** – The individual has received a Social Security Disability Award Letter and submits it to the Fund Office within 90 days from the letter date on the Social Security Disability Award Letter.
2. **Active Coverage** – The individual has an “Active” level of coverage on the date the Social Security Disability Award Letter deems you disabled.
3. **15 Consecutive Years** – The individual has earned or paid for an “Active” level of coverage for benefits through the Health Fund for at least 15 consecutive years prior to the date of disablement. Any year in which you decide to Opt-out of Level 1 or Level 2 coverage will NOT count towards your 15 consecutive year requirement.
4. **Pension** – The individual qualifies for, and is receiving, a Pension through the New Jersey Carpenters Pension Fund.
5. **Union Dues** – The individual’s union dues are paid up to date with his or her Local Union.

## **HIPAA Notice of Special Enrollment Rights**

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

- A change in family status, such as marriage, divorce, birth, adoption, placement for adoption, or death. A new spouse becomes covered effective the first day of the month following the date of your marriage, as long as coverage is requested, and a marriage certificate is received within 30 days of that date. A new dependent child becomes covered as of the date of birth or adoption, so long as coverage is requested within 30 days of that date.

- You previously stated in writing that you and/or your dependents were waiving Fund coverage because of coverage under another medical plan, and that other coverage is lost for any of the following reasons:

- termination of employment;
- reduction in hours worked;
- your spouse dies;
- you and your spouse divorce or legally separate;
- the other coverage was COBRA continuation coverage, and you or your dependent reaches the maximum length of time for COBRA continuation coverage; or
- the other plan terminates because the employer, or other sponsor, did not pay the premium when due.

## **TERMINATION OF BENEFITS**

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

- The last day of the month in which you are no longer an Active Participant;
- The last day of the month in which the employee or dependent fail to satisfy any eligibility requirements set forth in this plan;
- The date on which an employee first ceases to work or be available for work under a Collective Bargaining Agreement that requires contributions to this Fund;
- The date on which a modification, amendment, or termination by the Trustees of this Plan results in a loss of eligibility for the employee or eligible dependents;
- The date of a divorce or legal separation. The participant must submit a copy of a divorce decree or other applicable court order to the Fund Office within 30 days of a legal and finalized divorce or legal separation.

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

## **CONTINUATION OF COVERAGE**

**COBRA** – In compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), the New Jersey Carpenters Health Fund will offer continuation of group health coverage for members and their dependents, known as “qualified beneficiaries,” whose coverage would otherwise end as a result of a “qualifying event”. If you lose active coverage because you experience a Qualifying Event, then COBRA is the exclusive method by which you may continue your coverage in this Plan. In such a case, if you timely elect COBRA and are otherwise eligible, your current HRA balance will be applied to reduce the applicable monthly premium for COBRA coverage. Once your current HRA balance is exhausted, you will be responsible for timely payment of the applicable full monthly COBRA premium.

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

- Death of a member
- Divorce or Divorce from Bed and Board
- Child losing dependent status
- Eligibility for Medicare

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

**For Employees**

- Loss of Active Participant status
- Termination of employment (for reasons other than gross misconduct on your part)

**For Spouses**

- Death of a covered employee
- Member’s loss of Active Participant status or termination of your spouse’s employment (for reasons other than gross misconduct)
- Divorce or Divorce from Bed and Board from your spouse
- Your spouse becomes eligible for Medicare/Medicaid

**For Dependent Children**

- Death of a covered parent
- Loss of Active Participant parent’s employment (for reasons other than gross misconduct)
- Divorce or Divorce from Bed and Board of your parents
- The dependent no longer meets the definition of a “dependent child” as defined under the Health Plan
- The covered parent becomes eligible for Medicare/Medicaid

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

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

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

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

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

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

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

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

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

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

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

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

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

If the employee’s family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, the employee’s spouse and dependent children can obtain up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension is available to the spouse and dependent children receiving Continuation Coverage if the employee dies or gets divorced or if the

dependent child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.**

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

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

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

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

### **COBRA and HRA Coverage**

You and your Dependents also have an independent right to continue your eligibility for HRA benefits under COBRA upon the occurrence of a qualified event. For example, if you cease to be an Active Participant you can elect to continue your eligibility for benefits under the HRA for up to 18 months from the last day of the month that you were no longer an Active Participant, provided you pay the Fund Office the required premiums. Once the Fund Office receives your COBRA premiums, it will credit your HRA as required by law. If your HRA balance is sufficient to cover claims submitted beyond the 18 month COBRA period, eligible claims will be paid, but you will not be entitled to a COBRA election upon the exhaustion of your HRA balance.

Similarly, if you divorce, or if your Dependent children lose Dependent status under the Plan, your spouse and Dependent children, as applicable, have a right to receive benefits from the HRA for up to 36 months under COBRA, provided they pay the required COBRA premiums to the Fund.



Upon your death, your Dependents may continue seeking reimbursements from your HRA until the HRA is exhausted or until there has been 36 months of no reimbursements. If your HRA balance is exhausted within 36 months of your death, your Dependents can elect to continue coverage under the HRA under COBRA for up to 36 months from the date of your death, provided they pay the required premiums.

## **CONTINUATION OF COVERAGE DURING MILITARY LEAVE**

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

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

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

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

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

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

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

## **DEATH OR ACCIDENTAL DEATH BENEFITS**

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

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

## **ACCIDENTAL DISMEMBERMENT BENEFITS**

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

## **ASSIGNMENT OF BENEFITS**

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

If you obtain services from an in-network provider, the provider will be paid directly. However, should you obtain services from an out-of-network provider, payment will be made directly to you or your eligible dependents over 18 years of age. Assignment of benefits will not be honored for any out-of-network medical providers. It is your responsibility to pay the provider.

## **COORDINATION OF BENEFITS**

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

A member's spouse that is able to receive health benefits from their employer must do so. If your spouse has the ability to receive health benefits from their employer, but elects not to, they will be ineligible to receive any benefits from the New Jersey Carpenters Health Fund. If your spouse has already elected not to receive health benefits from his/her employer, your spouse must immediately reinstate this coverage at the first opportunity.

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

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

### **Order for Payment - More than One Group Insurance Covers a Dependent Child:**

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

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

- The plan which covers a child of a parent who has financial responsibility for healthcare expenses of the child through a court decree will be the primary plan and pay benefits first.

- If a court decree is not specific:
  1. the plan of the parent with custody pays first;
  2. the plan of the spouse of the parent with custody (i.e. step-parent) pays second; and,
  3. the plan of the parent without custody pays last.

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

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

## **REPORTING OF INJURIES**

The Fund Office must be notified of the following events:

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

## **SUBROGATION AND REIMBURSEMENT**

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

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

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

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

Persons covered under this Plan agree, upon accepting payment of benefits, to give a 10-day notice to the Fund Office of any steps to be taken to recover any monies from a third party (or their insurance carrier) including identifying the attorney retained for the purposes of seeking recovery and any appropriate carrier. If an action is commenced by the recipient of benefits, or his attorney, the recipient agrees to give notice of the action, to report periodically on the progress of the action and to give at least a 30-day notice prior to any pretrial conference. The Fund

reserves the right to attend such pretrial conference and to otherwise intervene in the action if deemed necessary by the Fund; however, the Fund need not intervene in order to secure its right to a lien, an assignment, subrogation or reimbursement.

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

## **OVERPAYMENTS**

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

## **AUTOMOBILE ACCIDENTS**

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

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

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

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

## **MOTORCYCLE / RECREATIONAL VEHICLE ACCIDENTS**

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

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

## **MEDICAL NECESSITY**

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

- be recognized by the American Medical Association (AMA) as appropriate and consistent with the symptoms, diagnosis and treatment of your illness or injury;
- be given to you as an inpatient only when the services cannot be safely provided as an outpatient or out of the hospital;
- not be provided solely for the convenience of your physician, hospital, other provider or you;

- not be experimental, investigational or educational in nature; or
- not be for the purpose of research or other arrangement which may require medical or psychiatric monitoring, treatment or procedures of any kind.

Notwithstanding the foregoing, effective for all claims incurred on or after January 1, 2014, Medical Necessity shall include, subject to the terms of Public Health Service Act 2709(d), routine patient costs for items and services furnished in connection with participation in an approved clinical trial. An approved clinical trial is one that relates to treatment of cancer or other life-threatening disease or condition. Under no circumstances will the plan cover: (1) the investigational item, device, or service itself; (2) any items or services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the participant; or (3) any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. This means that if a participant participates in a prescription drug trial, the plan will not pay the costs of the drug but will pay any costs associated with administering the drug. To the extent that an in-network provider accepts your participation in an Approved Clinical Trial, you must use this provider.

Approved Clinical Trials are only: trials federally funded by the National Institute of Health, the Center for Disease Control, the Agency for Healthcare Research and Quality, and the Center for Medicare & Medicaid Services (or any cooperative group of these entities); a study or investigation conducted under an investigational new drug application reviewed by the FDA; or a drug trial that is exempt from having an investigational new drug application.

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

### **Notice of New Jersey Carpenters Health Fund Privacy Practice**

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



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

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

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

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

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

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

### **Other Uses and Disclosures Require Your Authorization –**

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

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

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

**Individual Rights** – You have certain rights under the Federal privacy standards. They include:

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

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

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

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

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

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

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

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

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

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

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

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

### **Contact Person**

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

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

This notice is effective on or after April 14, 2003.

### **PLAN SPONSORS' USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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

The Board of Trustees agrees to:

- a. Not use or further disclose such PHI other than as permitted or required by the Plan or as required by law;
- b. Ensure that any agents of the Trustees to whom they provide PHI received from the Fund must agree to the same restrictions and conditions that apply to the Trustees with respect to such information;

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

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

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

## **CERTIFICATES OF CREDITABLE COVERAGE**

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

The Certificate of Creditable Coverage will be provided to you:

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

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

## **HOW TO SUBMIT CLAIMS TO THE FUND OFFICE**

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

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

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

**MAJOR MEDICAL/CO-PAY SERVICES** – Benefit payments under your Major Medical/Co-Pay Plan will be made directly to you with the exception of the services or supplies that are rendered by our participating

providers. Do not pay participating providers at the time services are rendered. The participating providers will submit the claim on your behalf, with the exception of appropriate co-payments. The \$200.00 family deductible will be waived for participating providers. You must submit a claim for all other Major Medical expenses. You will be reimbursed 80% of our fee schedule for eligible medical expenses upon receipt of your properly completed and substantiated "Health Insurance Claim Form". Upon receipt of the E.O.B. "Explanation of Benefits", you will be able to determine your co-payment, if any.

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

**Contact the Fund Office to obtain the appropriate claim forms.**

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

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

### **APPEAL FOR TIMELY FILING**

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

#### **Proof of timely filing must consist of:**

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

### **CLAIMS APPEAL FROM PROVIDERS**

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

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

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

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

## **CLAIMS, DENIALS & APPEALS**

### **Notice of Denial**

If your claim for benefits is denied wholly or in part, the Plan Administrator shall notify you of such denial in writing. In addition, in the case of a rescission of coverage involving your alleged fraudulent conduct or intentional misrepresentation to the Plan, the Plan Administrator shall notify you of such rescission in writing. As described below, the deadline for such notice from the Plan Administrator will depend upon the type of claim being denied.

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

In the case where the Fund has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Fund (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute



a denial of benefits. The Plan Administrator shall notify you of such denial at a time sufficiently in advance of the reduction or termination on review to allow you to appeal and obtain a determination on review of the denial before the benefit is reduced or terminated. Any request by you to extend the course of treatment beyond the period of time or the number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Fund, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. (See appeal rules below for right to continuation of ongoing course of treatment during period when appeal is pending).

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

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

In the case of a claim for Accidental Dismemberment benefits, the Plan Administrator shall notify you of the Fund's denial of your claim within a

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

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

Any written notice of the denial of a claim for benefits shall: (a) set forth the specific reason or reasons for the denial; (b) refer to the specific Plan provisions on which the denial is based; (c) set forth a description of the claim at issue including the date of service, the provider, and the claim amount; (d) include a statement that the applicable diagnosis code and meaning and/or treatment code and meaning are available upon request from the Fund Office; (e) describe any additional material or information necessary for you to perfect the claim and explain why such material or information is necessary; (f) include the contact information for organizations that may assist you with your claim, if any; and (g) describe the Fund's review procedures and the time limits applicable to such procedures, including a statement of your right to initiate an external review (as described below) and/or bring a civil action under section 502(a) of ERISA following a denial on review.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, the notice shall include either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in reaching the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. Moreover, if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. If the denial concerns a claim involving urgent care, the notice will describe the expedited review process applicable to such claims.

### **Appeal of Denied Claims**

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

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

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

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

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

If the Trustees consider, rely upon, or generate any new or additional evidence or rationale in the course of reviewing your appeal, you will be provided with such evidence or rationale, free of charge, as soon as possible and sufficiently in advance of the Trustees' determination on appeal so that you have a reasonable opportunity to respond.

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

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

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

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

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

In the case where the Fund initially approved an ongoing course of treatment to be provided over a period of time or number of treatments but subsequently reduced or terminated the treatment, the Fund will continue to provide such coverage while it considers your appeal (and, as discussed below, during the period of an external review, if any).

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

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

The Plan Administrator shall provide you with written notification of the Fund's benefit determination on review. In the event your appeal is denied, the written notice of the denial of the appeal shall: (a) set forth the specific reason or reasons for the denial; (b) refer to the specific Plan provisions on which the denial is based; (c) set forth a description of the claim at issue including the date of service, the provider, and the claim amount; (d) include a statement that the applicable diagnosis code and meaning and/or treatment code and meaning are available upon request from the Fund Office; (e) state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; (f) include the contact information for organizations that may assist you with your claim, if any (g) describe your right to initiate an external review (as described below) and/or bring a civil action under section 502(a) of ERISA.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, the notice shall include either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in reaching the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

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

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

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

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

## **External Appeals**

Federal law gives you the right to file an external appeal of certain denials of benefits if the initial denial is upheld by the Trustees after the internal appeal process. Pursuant to the law, participants may only request external appeals when denied benefits on the basis of medical judgement: e.g. determinations of medical necessity, appropriateness, place of treatment, level of care, effectiveness of covered benefits, or whether the applicable treatment is a non-eligible experimental treatment. If the denial of benefits does not relate to any of the above, the claim will be deemed ineligible for external review. Amongst other things, this means that you may not use the external review process to appeal a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility set forth in this SPD.

Federal law also gives you the right to an external appeal after an initial denial but only if the appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal (72 hours) would seriously jeopardize your life or health or your ability to regain maximum function. You must expressly request an expedited external review if this option applies to you. If your claim is not eligible for expedited external review, as discussed below, you must complete the internal appeal process before seeking external review.

Subject to the above requirements and limitations, you will have the right to pursue an external appeal with an Independent Review Organization (IRO). To exercise this right, you must request an external appeal in writing within four months after receiving our final internal appeal decision (the Trustees' decision) regarding your claim. The notice provided after an initial denial and final internal appeal decision will provide full details regarding the process that must be followed to request and obtain an external review. A small filing fee may be required. If so, it will be noted in the notice. If the process for obtaining this review is successfully completed, and your claim is deemed eligible, you will be notified and your appeal will be assigned to an IRO. Once it is assigned, the IRO will notify you about any additional steps that must be taken to complete your appeal. Once all of these additional steps are completed, the IRO will review all of the information in your case as if it were new. The IRO is not bound by any decisions or conclusions that were reached during the internal appeals process.

If your appeal is not an expedited request, the IRO's decision will be communicated to you in writing within 45 calendar days after its receipt of the appeal. In the event your external appeal request was handled on an expedited basis due to your medical circumstances, the IRO will notify you of its decision as soon as possible, but no later than 72 hours following receipt of your request. In both circumstances, the written decision issued by the IRO will include complete information regarding your appeal and the rationale for the decision. The decision will also include a statement that the IRO's decision is binding on both the Plan and you, except to the extent that other remedies may be available to you or the Plan pursuant to State or Federal law. The decision will also advise you about other resources that may be available to you for additional assistance.

## **YOUR RIGHTS UNDER ERISA**

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

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan are called "fiduciaries" of the Plan and have a duty to operate the Plan prudently and in the interest of you and



other Plan participants and their beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision, or lack thereof, regarding the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

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

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

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

## **Other Information You Should Know**

### **Financing the Plan**

Contributions to the Fund are made primarily by Employers that have entered into Collective Bargaining Agreements with the Union or participation agreements with the Fund, requiring that contributions be made to the Fund.

### **How Benefits May Be Forfeited or Delayed**

There are certain situations under which self-insured benefits may be forfeited or delayed, such as if you:

- do not timely submit a claim for self-insured benefits;
- do not provide the information required to complete or verify a claim for a self-insured benefit; or
- do not have a current address on file with the Fund Office.

Plan benefits are not payable for any enrolled Dependent who is ineligible due to age, divorce or divorced from bed & board unless such Dependent elects to continue coverage under COBRA, as described on page 52.

### **No Liability for the Practice of Medicine**

Neither the Fund, nor the Board of Trustees or any of its designees:

- are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any healthcare services provided or delivered to you by any healthcare provider; and
- will have any liability whatsoever for any loss or injury caused by any healthcare provider by reason of negligence, failure to provide care or treatment, or otherwise.

### **Compliance with Law**

The Fund is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor and current tax and ERISA laws. The provisions in this booklet will always be construed to comply with these regulations, rulings and laws.

## **Plan Amendment or Termination**

The Board of Trustees intends to continue the Plan indefinitely, but reserves the right to amend or terminate it in its sole discretion. Please remember that benefits provided under this Plan are not vested. Therefore, at any time, the Board can end or amend benefits, including but not limited to, retiree benefits, in its sole and absolute discretion.

## **Fraud**

The Board of Trustees reserves the right to cancel or rescind Fund coverage for any Participant or Dependent who willfully and knowingly engage in any activity intended to defraud the Plan to the extent permitted by applicable law. Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in dependent status, accepting benefits after your eligibility ends or in excess of what is covered under the Plan, submitting false documentation of expenses, accepting reimbursement of an ineligible expense from your HRA, will be considered fraud and the Fund will seek reimbursement.

## **Incompetence**

In the event it is determined by the Fund's Board of Trustees that someone who is entitled to benefits is unable to care for his affairs because of illness, accident or incapacity, either mental or physical, any payment due may, unless the claim has been made by a duly appointed guardian, committee or other legal representative, be paid to the individual's spouse or other person having care and custody of the claimant or such person having the claimant's Power of Attorney, as the Board of Trustees will determine in its sole discretion.

## **Cooperation**

Every claimant is required to furnish to the Board of Trustees all such information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Fund. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment of benefits. The Board of Trustees will be the sole judge of the standard of proof required in any case, and may from time to time adopt such formula, methods and procedures as the Board considers reasonable.

## **Mailing Address**

In the event that a claimant fails to inform the Board of Trustees of a change of address and the Board is therefore unable to communicate with the claimant at the address last recorded and a letter sent by first class mail to such claimant is returned, payments due the claimant will be held without interest until payment is successfully made.

## **Coordination of HRA/Self-insured Benefits with Medicare & Other Programs (Active Employees Age 65 and Over and Their Dependents)**

Generally, the Fund's self-insured benefits, including HRAs, will be primary for participants working in Covered Employment over the age of 65 and their spouse. However, if you are receiving self-insured benefits from the Fund under COBRA, Medicare will be primary, to the extent permitted by applicable law. Also, an active employee or spouse may decline coverage under the Plan and elect Medicare as primary. In that instance, the Fund will not pay benefits secondary to Medicare for Medicare covered services. In the event Medicare seeks reimbursement from the Fund for amounts for which the Fund should have paid primary from your HRA, but did not, such amounts will be deducted from your HRA. In the event your HRA has an insufficient balance, the individuals to whom the claims apply shall be responsible for reimbursement to Medicare, not the Fund.

## **Disabled Employees or Disabled Dependents Under 65**

If you or your Dependents become eligible for Medicare due to disability while you are actively working in Covered Employment, this Plan will provide your primary coverage and Medicare will be secondary for as long as you continue to work in Covered Employment. If you are not working in Covered Employment, and you or your Dependents become eligible for Medicare due to disability, Medicare is primary and this Plan is secondary for each covered family member eligible for Medicare. Any covered family members not eligible for Medicare will receive primary coverage under this Plan, (If currently enrolled in NJCHF Level 1 or Level 2 Family coverage).

## **End Stage Renal Disease**

For Participants and Dependents with end-stage renal disease, Medicare is the secondary payer during the first 30 months of treatment. After this 30-month period is over, Medicare becomes the primary payer, subject to Medicare guidelines. Please contact the NJ Carpenters Funds for further information.

## **Medicaid**

If you are covered by both this Plan and Medicaid, this Plan is primary and Medicaid pays secondary.

## **Definitions**

**Certain words have specific meanings with respect to the Fund. These words are capitalized throughout the SPD.**

**Active Participant** means a Participant working for a union signatory employer under a Collective Bargaining Agreement for a New Jersey shop, casino maintenance agreement, or any other category of employees that the Trustees in their discretion choose to designate as eligible for participation in this Plan. You can lose Active Participant status if your Employer is delinquent in its contributions to the Fund or if a Reciprocal Welfare Fund has not transferred contributions to the Fund on your behalf.

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

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

**Benefit Year** – January 1st thru December 31st.

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

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

**Casino Maintenance Employee** is an “in-house” union carpenter employed at a New Jersey casino, including but not limited to, carpet and flooring mechanic, locksmith, gaming mechanic and upholsterer.

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

**Contributing Employer** is any employer that has signed a collective bargaining agreement with the Union that requires contributions to be made to the Fund on behalf of an employee working in a covered area.

**Co-payment** means the fixed out-of-pocket fee you pay for certain covered services.

**Co-insurance** generally refers to a percentage of your claim that you are required to pay out-of-pocket to a provider in addition to any required co-payment.

**Covered Employment** means work in a job classification for which your Contributing Employer is required to make contributions to the Fund on your behalf. If you work in employment covered by a Reciprocal Welfare Fund and your contributions to the other fund are properly transferred to this Fund, the hours you work for which contributions are made to the Reciprocal Welfare Fund will be counted as hours of Covered Employment under this Fund.

**Deductible** generally refers to an amount you are required to pay out-of-pocket for your medical expenses before your insurance coverage applies.

**Dependent** means a person who meets the requirements beginning on page 22 and as a result, is eligible for participation in the Plan.

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

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

**Eligible Medical Expenses** means expenses for which you can seek reimbursement from your HRA. Eligible Medical Expenses must be tax deductible under Section 213d of the Internal Revenue Code for which you have not otherwise been reimbursed from insurance or from some other source. To be considered an Eligible Medical Expense under this Health Plan, the expense must be included in Appendix A of this SPD, as amended from time to time, and satisfy the other requirements of this SPD.

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

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

**Explanation of Benefits (E.O.B.)** means a document that you receive from a claims administrator that explains the extent of coverage provided for a certain service or supply.

**Experimental** means treatment that, for the particular diagnosis or treatment of the covered person's condition, is not of proven benefit or is not generally recognized by the medical community (as reflected in published medical literature). Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Any or all of the following criteria may be required to be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- There is final market approval by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met;
- Published peer-review medical literature must conclude that the technology has a definite positive effect on health outcomes;
- Published evidence must show that over time the treatment improves health outcomes (e.g., the beneficial effects outweigh any harmful effects);
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

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

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

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

**HRA** – Health Reimbursement Arrangement as defined by the Internal Revenue Service. Also, Healthcare Reimbursement Account, term used to describe an individual's personal account.

**Inpatient** – A patient registered for occupancy in a hospital.

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

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

**Medically Necessary** means services, supplies or durable medical equipment that are:

- Consistent with the symptoms or diagnosis and treatment of the patient’s condition, illness or injury,
- In accordance with standards of good medical practice,
- Not solely for the convenience of the patient, the family or the provider,
- Not primarily custodial,
- The most appropriate level of service that can be safely provided to the patient,
- Not cosmetic, and
- Not Experimental.

Notwithstanding the foregoing, Medical Necessity shall include, subject to the terms of Public Health Service Act 2709(d), routine patient costs for items and services furnished in connection with participation in an approved clinical trial. An approved clinical trial is a one that relates to treatment of cancer or other life-threatening disease or condition.

The fact that a provider may have prescribed, recommended or approved a service, supply or durable medical equipment does not, in itself, make it medically necessary. (See page 63-64 for more details.)

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

**NJCHF** – New Jersey Carpenters Health Fund

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



**Open Enrollment Period** means the period of time beginning each November 15 and ending on each December 31 for coverage beginning the following January 1.

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

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

**Participant** means a person who works in Covered Employment for a Contributing Employer who meets the requirements for participation in the Plan as described beginning on page 16.

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

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

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

**Preventive Services** – Those services that the U.S. Preventive Services Task Force designates as preventive services for adults, women, and children pursuant to the Patient Protection and Affordable Care Act.

**Reciprocal Health & Welfare Fund** means a health & welfare fund affiliated with the United Brotherhood of Carpenters and Joiners of America that is party to an agreement requiring that contributions made to it on behalf of Participants covered by this Plan be transferred to the NJ Carpenters Health Fund upon request of the Participant.

**Special Enrollment** – A HIPAA requirement stating the Fund must guarantee participants and dependents, not otherwise enrolled for coverage from the Fund, special enrollment rights if certain qualifying events occur, (See page 51 for more details.)

**Shop Employee** is a union carpenter affiliated with Local 252 employed at a New Jersey shop that has a collective bargaining agreement with the Northeast Regional Council of Carpenters (NRCC). This includes, but is not limited to, a cabinetmaker, assembler, laminator, utility worker and warehouseman. Also included are all others classified in shop and/or industrial contracts.

**Spouse** is your legal married partner or civil partner joined in a civil union recognized by a State in which the civil union occurred.

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

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

**Union** means the Northeast Regional Council of Carpenters (NRCC), or its successor, affiliated with the United Brotherhood of Carpenters and Joiners of America.

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**NORTHEAST REGIONAL COUNCIL OF CARPENTERS**

LOCAL UNION #255

(Formerly – LU 121, 393, 542, 623, 1489, 1743, 2018 & 2250)

LOCAL UNION #254

(Formerly – LU 31, 155, 455, 620, 781, & 1006)

LOCAL UNION #253

(Formerly – LU 6, 15, 124 & 1342)

LOCAL UNION #252

Mill Cabinet

(Formerly – LU 821 & 2098)

LOCAL UNION #251

Floorlayers

(Formerly – LU 29 & 2212)

LOCAL UNION #715

Millwrights

LOCAL UNION #39

Tapers

**AFFILIATED GROUPS  
EMPLOYERS GROUPS**

Building Contractors Association of New Jersey

Associated General Contractors of New Jersey

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

**RECIPROCAL AGREEMENTS**

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

## **MERGER DATES**

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

## **TERMINATION OF THE FUND**

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

## APPENDIX A

### Eligible Medical Expenses for Reimbursement from your HRA

**Please remember that just because an expense is included on this list, does not mean that it is automatically reimbursable from the HRA. All the applicable requirements described in the SPD must be met in order for your claim to be eligible for reimbursement. In addition, the Fund reserves the right to request additional information that is not included in this Appendix to determine whether a particular expense is reimbursable.**

Healthcare Expense Type	Substantiation Requirements
<p><b>Co-Payments, Co-insurance, Deductibles and expenses that exceed the Usual or Customary Charges paid to out-of-network providers for expenses. This includes, but is not limited to, doctors, hospitals, urgent care facilities, laboratory services, radiology services, ambulance transport, mental health services, substance abuse treatment, orthotics and prosthetics.</b></p>	<ul style="list-style-type: none"> <li>• Explanation of Benefits (EOB) is preferable</li> <li>• Proof of Payment</li> <li>• If an EOB is not available, you may submit an itemized bill which must include the following:               <ol style="list-style-type: none"> <li>1. Date of service</li> <li>2. Patient Name</li> <li>3. Description of services rendered (procedure code) and diagnosis code if available</li> <li>4. Cost of Services rendered and proof of payment</li> <li>5. Name and address of provider.</li> </ol> </li> </ul>
<p><b>Medical Premiums</b></p> <ul style="list-style-type: none"> <li>• Post-tax medical, dental or vision premiums that are paid to a qualified individual or group health plan.</li> <li>• Medicare</li> <li>• COBRA premiums that are paid to a qualified individual or group health plan</li> <li>• Premiums that are self-paid to the Fund with after-tax dollars during a period on which your Employer is delinquent</li> </ul>	<ul style="list-style-type: none"> <li>• Acceptable Proof:               <ol style="list-style-type: none"> <li>1. Proof that premiums are paid with “after tax dollars,” such as a letter from Human Resources or Payroll department.</li> <li>2. Paycheck stub showing the amount of premiums paid. Pay stub must also include: date the check was issued, name of person the check is issued to and the amount of premium deducted.</li> <li>3. Proof that the plan is a qualified individual or group health plan.</li> <li>4. Copies of Medicare statements or invoices are acceptable.</li> <li>5. For COBRA premiums, proof must include a letter from the Plan Administrator certifying the COBRA rate and proof that you have paid the full premium.</li> </ol> </li> </ul>

## APPENDIX A (Continued)

### Eligible Medical Expenses for Reimbursement from your HRA

Healthcare Expense Type	Substantiation Requirements
<b>Dental and Orthodontic Services</b>	<ul style="list-style-type: none"><li>• Explanation of Benefits (EOB)</li><li>• Proof of Payment</li><li>• Orthodontics also require the following:<ol style="list-style-type: none"><li>1. Signed and dated Orthodontic contract with provider information, patient name, payment plan selected and what the insurance company is estimated to pay</li><li>2. If the Participant does not have dental insurance, the Participant must submit a signed orthodontic contract and an itemized bill which includes the date services began, patient name, services rendered, and cost for the services</li></ol></li></ul>
<b>Drugs/Medicines – Prescriptions</b>  <b>FDA legend drugs only.</b>  <b>No over-the-counter drugs.</b>	<ul style="list-style-type: none"><li>• Documentation from the Pharmacy that must include all of the following:<ol style="list-style-type: none"><li>1. Name and Address of Pharmacy</li><li>2. Name of patient</li><li>3. Name of Drug</li><li>4. Cost of Drug and any amounts covered by insurance</li><li>5. Prescribing doctor</li></ol></li><li>• Proof of Payment</li></ul>
<b>Vision Care</b> <ul style="list-style-type: none"><li>• Contact lenses</li><li>• Laser surgery</li><li>• Eye examinations by a licensed ophthalmologist, optometrist or optician</li><li>• Prescription Eyeglass Lens</li></ul>	<ul style="list-style-type: none"><li>• Explanation of Benefits (EOB) is preferable</li><li>• Proof of payment</li><li>• If an EOB is not available, you may submit an itemized bill which must include the following:<ol style="list-style-type: none"><li>1. Date of service</li><li>2. Patient name</li><li>3. Description of services rendered (procedure code) and diagnosis code if available</li><li>4. Cost of services rendered and proof of payment</li></ol></li></ul>



## APPENDIX A (Continued)

### Eligible Medical Expenses for Reimbursement from your HRA

Healthcare Expense Type	Substantiation Requirements
<p><b>Hearing</b></p> <ul style="list-style-type: none"> <li>• Purchase price and maintenance cost for hearing aids</li> <li>• Batteries needed to operate the hearing aid</li> <li>• Hearing exams</li> </ul>	<ul style="list-style-type: none"> <li>• Explanation of Benefits (EOB)</li> <li>• Letter of Medical Necessity</li> <li>• Proof of payment</li> <li>• If an EOB is not available, you may submit an itemized bill which must include the following:               <ol style="list-style-type: none"> <li>1. Date of service</li> <li>2. Patient name</li> <li>3. Description of services rendered (procedure code) and diagnosis code if available</li> <li>4. Cost of services rendered and proof of payment</li> </ol> </li> </ul>
<p><b>Durable Medical Equipment (Equipment must be an Eligible Medical Expense as per current Internal Revenue Service guidelines.)</b></p>	<ul style="list-style-type: none"> <li>• Copy of the prescription or proof that the equipment was prescribed</li> <li>• Letter of Medical Necessity</li> <li>• Proof of payment</li> <li>• Documentation that includes the following:               <ol style="list-style-type: none"> <li>1. Name and Address of Company proving the equipment</li> <li>2. Name of patient</li> <li>3. Type of Equipment</li> <li>4. Cost of Equipment and any amounts covered by insurance</li> <li>5. Prescribing doctor</li> </ol> </li> </ul>

Please see IRS Publication 502, IRS Code Section 213 (d) for a complete list of Eligible and Ineligible Medical Expenses. **However, be advised that at this time the Board of Trustees is limiting reimbursements to the Medical Expenses listed in the above appendix.**

The following list provides examples of items that are **NOT** eligible for reimbursement from your HRA. This list is provided as an example and is not exhaustive.

Foods and Beverages  
 Cancellation Fees  
 Missed Appointment Fees  
 Late Payments  
 Shipping Fees  
 Athletic Club membership  
 Swimming Pool, Hot Tubs  
 Weight loss programs

Massage Therapy  
 Cosmetic Surgery and procedures  
 Non-prescription medicine  
 Acne Treatments  
 Suntan Lotion  
 Vitamins  
 Dietary Supplements  
 Exercise Equipment

– NOTES –

– NOTES –

– NOTES –