New Jersey Carpenters
Retired Health Plan

NJCF

Summary Plan Description

Effective April 1, 2011

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RETIRED NON-MEDICARE HEALTH PLAN BENEFITS (Con't.)

FISCAL YEAR (PLAN YEAR)
April 1 through March 31

This document constitutes the entire NJ Carpenters Retired Health Plan and, it also serves as the Summary Plan Description of the NJ Carpenters Retired Health Plan as of April 1, 2011.

Due to the fact this booklet is not printed annually, you may learn about new Plan amendments by contacting the NJ Carpenters Fund Office by the following methods:

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

"Benefit Watch"
(Quarterly newsletter of the NJ Carpenters Fund)

Website: www.njcf.org
(Down-load printable version of updated Retired Health Plan)

The NJ 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 such is not subject to state insurance laws.

NEW JERSEY CARPENTERS
RETIRED HEALTH PLAN
(Plan No. 501)

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(I.D. No. 22-6032181)

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THIRD PARTY ADMINISTRATORS
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
MEDCO

To All Eligible Retired Participants,

The Board of Trustees of the New Jersey Carpenters Health Fund is providing you with this booklet explaining the benefits and rules of your Retired Health Plan Benefits.

If you would like more information concerning the benefits available to you under the Retired Health Plan, you can contact the Fund Office at 1-800-624-3096.

Sincerely yours,

THE TRUSTEES

GENERAL INFORMATION

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

The Board of Trustees reserves the right to amend or modify the Retired Health Plan, in whole or in part, at any time, including retroactive amendments. The authority to make any such changes to the Retired 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 Retired Health Plan offers the benefits described herein through self-funding and insurance. Currently, all benefits are self-insured with the exception of the Medicare eligible participants enrolled in the Medco Medicare Part D Drug Program. The benefits of this Fund are provided only to the extent that assets are available in the judgment of the Trustees, considering all liabilities of the Fund, and the desire of the Trustees to maintain the benefits or provide other benefits. Although the Trustees hope to provide benefits indefinitely into the future, benefits (or a specific level or type of benefits) are subject to change and this Plan does not create a contractual right to continued receipt of benefits currently provided herein.

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

IMPORTANT INFORMATION YOU SHOULD KNOW

A "Retired" individual is anyone who is currently receiving a Pension through the New Jersey Carpenters Pension Fund, with the exception of those individuals who continue to work and meet ALL the eligibility requirements under the "Active" level of benefits. Please contact the Fund Office for more details.

This coverage is provided by the Fund. It will continue to be provided as long as the Trustees in their judgment believe it is feasible to continue such coverage. The Trustees reserve the right to modify, suspend or permanently discontinue the Retired Health Plan Benefits at anytime, with or without prior notice. There are no vested or accrued rights to benefits in the Retired Health Plan. Furthermore, no vested or accrued right shall be deemed to have arisen because it is part of this benefit program at the present time, and there shall not be deemed to be any right to receive this coverage as a consequence of an individual's status as a past employee. In the event the Retired Health Plan Benefits are terminated without being replaced with comparable benefits, retirees would be notified of the alternative available, if any, such as conversion or continuation privileges.

Benefits mandated by the Patient Protection and Affordable Care Act (PPACA) do not apply to participants in the Retired Health Plan:

PREMIUM PAYMENTS

Monthly premium payments for participation in the NJ Carpenters Retired Health Plan are due on the 1st day of every month. There is no billing invoice; it is your responsibility to make your premium payments to the Fund Office by the first of every month. Failure to pay your premium will result in your termination from the NJ Carpenters Retired Health Plan. Retired eligibility rules apply.

SPECIAL REIMBURSEMENT BENEFITS

Prior to April 1, 2011, this Plan included Special Reimbursement Benefits of up to $10,000 per lifetime for medical reimbursements ($20,000 if married) and $750 per year for prescription reimbursements ($1500 if married). The Special Reimbursement Benefits were available to any individual who otherwise qualified as an Eligible Retired Participant but who was unable to or failed to make required premium payments under this Plan. Effective April 1, 2011, the Plan will no longer offer Special Reimbursement Benefits to any individuals other than

those who are receiving the benefits as of March 31, 2011. No new individuals will be provided Special Reimbursement Benefits.

RETIRED HEALTHCARE BENEFITS

Below are the current healthcare benefits available for retired eligible participants and their eligible dependents. These benefits are explained in greater detail throughout this booklet. Mandated health benefits by PPACA do not apply to these coverages, eligibility rules apply.

1. **Non-Medicare Retired Health Plan** – Currently offered through the NJ Carpenter Funds to qualified members ages 55 through 64, and their dependents up to age 22 if they are full-time students. Eligibility rules apply.

2. **Medicare Retired Supplemental Plan** – This benefit is provided for a retiree age 65 or older and/or, their eligible spouse, age 65 or older; or for permanently disabled individuals eligible for Medicare disability coverage. It pays all Medicare deductibles including Part A and Part B and 20% of all Medicare approved charges. The Medicare Retired Supplemental Plan is only available to offset medical expenses covered by Medicare Part A and Part B when the covered individual incurs a medical liability.

3. **Disability Health Provision** – Upon receiving a permanent Social Security Disability award, along with meeting the eligibility requirements of this provision, members may qualify for the Retired Health Plan. All Retired Health Plan rules apply to members in this category.

MANDATORY PARTICIPANT NOTIFICATION

The Fund Office must be notified of the following events:

- **Change of Address / Telephone Number**
- **Divorce from your Spouse**
- **Death of member or dependent**
- **Addition or change in your spouse's health insurance**
- **Eligibility for Medicare or Medicaid**
- **Change of beneficiary**
- **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.**

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 Retired Health Plan. 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 Retired Health Plan 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 contact the Fund Office. Refer to the section titled SUBROGATION AND REIMBURSEMENT for information relating to the Plan's rules should you decide to pursue a lawsuit against the automobile insurance carrier or other entity.

MOTORCYCLE / RECREATIONAL VEHICLE ACCIDENTS

All Level 2 Major Medical 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 Hospital and Medical-Surgical 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 Hospital and Medical-Surgical 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.**

RETIRED ELIGIBILITY

A retired individual qualifies for benefits and is an Eligible Retired Participant under this Retired Health Plan if all of the following conditions are satisfied:

1. **AGE 55** – The individual is age 55 or over at the time of retirement and is currently receiving a pension through the NJ Carpenters Pension Fund;
2. **YEARS OF ACTIVE COVERAGE** – The individual has been covered under the Active Employees Health Plan for a period of years as follows:

   Hours of Service Prior to April 1, 2011: any individual who performed an hour of service under a Collective Bargaining Agreement requiring contributions to the NJ Carpenters Health Fund must have:

   20 years of Active Coverage if retired prior to April 1, 2010; or

   25 years of Active Coverage if retired on or after April 1, 2010.

   Hours of Service Beginning on or after April 1, 2011: any individual who first performed an hour of service on or after April 1, 2011, under a Collective Bargaining Agreement requiring contributions to the NJ Carpenters Health Fund must have:

   30 years of Active Coverage upon retirement;
3. **ACTIVE COVERAGE AT RETIREMENT** – The individual has a level of coverage under the Active Employees Health Plan at the time of retirement;
4. **UNION DUES** – The individual's union dues are paid up to date with his or her Local Union; and,
5. **PAYMENT** – The individual makes all premium payments required for coverage under this Plan on the 1st day of every month. Non-payment of premium results in termination.

Coverage obtained by (1) temporary disability credits (2) bank credits or (3) self-payment, such as COBRA or otherwise, under the Active Employees Health Plan are not included as part of the period of years of coverage for purposes of determining eligibility in this Plan.

BANKED CREDITS FROM THE ACTIVE EMPLOYEES HEALTH PLAN

Eligible Retired Participant

During the year a participant retires and qualifies as an Eligible Retired Participant in the Retired Health Plan, banked credits and/or current contributions will be applied to payments required for coverage under this Retired

Health Plan until exhausted. For example, an Eligible Retired Participant who is not Medicare eligible can apply his or her banked credits and/or current contributions toward the current required annual premium under this Plan, and an Eligible Retired Participant who is Medicare eligible can apply his or her banked credits and/or current contributions to the current monthly premium. Where banked credits and/or current contributions are insufficient to cover the full annual premium, the Eligible Retired Participant will be required to pay the difference between the value of available banked credits and/or current contributions and the applicable premium in order to maintain coverage in this Plan. Annual premiums are subject to change by the Board of Trustees. Contact the Fund Office for current premium rates.

In no case will an Eligible Retired Participant be permitted to use his banked credits and/or current contributions toward continuation of coverage in the Active Employees Health Plan.

Non-Eligible Retired Participant

If a retired individual does not qualify as an Eligible Retired Participant but, at the time of retirement, maintains banked credits and/or current contributions from the Active Employees Health Plan, then the individual will be eligible to participate in the Retired Health Plan until his or her banked credits and/or current contributions are exhausted as follows. The Plan will apply the banked credits and/or current contributions of the individual toward the then-current Medicare eligible premium or the non-Medicare eligible premium, whichever is applicable. For any Plan Year where the individual maintains a balance of banked credits and/or current contributions but the balance is insufficient to cover the applicable premium, the individual will be afforded an opportunity to purchase COBRA. If the individual does not so pay within the time specified by the Plan, then the individual forfeits the balance of any banked credits and is ineligible to participant in this Plan during the Plan Year and any subsequent Plan Years.

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

SPOUSAL COVERAGE

The spouse of an Eligible Retired Participant will be eligible for benefits from this Plan, provided the spouse was covered as an eligible dependent under the Active Employees Health Plan on the date of retirement. Divorced spouses, including spouses who are divorced from bed and board, and legally separated spouses are covered until the effective date of the divorce decree or other applicable court order.

It is the participant's responsibility to notify the Fund Office and provide a copy of the divorce decree or other applicable court order.

DEPENDENT CHILDREN COVERAGE

The "Adult Child" dependent coverage mandate under the Patient Protection and Affordable Care Act (PPACA) does not apply to the Retired Health Plan.

Dependent children must qualify as follows:

Dependent children of an Eligible Retired Participant will be eligible for benefits from this Plan provided the eligible dependent children were covered as an eligible dependent under the Active Employees Health Plan on the date of retirement and continue to meet the following guidelines of eligible dependent children.

Dependent children are your unmarried children under age 19 who are financially dependent upon you. Coverage for adopted children and stepchildren (who must reside in your home) is determined after the required information is submitted for review to the Fund Office. Children are covered until the first day of the month following their 19th birthday or until the date of their marriage, whichever occurs first.

Your eligible unmarried children between the ages of 19 and 22, who are full-time students attending accredited institutions of higher learning and are wholly dependent upon you for support, are also eligible dependents. Proof of full-time student status must be submitted to the Fund Office each semester. Coverage for full-time students ends the first day of the month following their graduation, or the first day of the month in which they cease to be a full-time student, or the first day of the month following their 22nd birthday, or the date of their marriage, whichever occurs first.

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

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

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

HEALTH DEATH BENEFIT

There is no Health Death Benefit available through the New Jersey Carpenters Retired Health Plan.

Coverage after Retired Participants Death

Upon the death of a retired participant the surviving spouse and eligible dependents will be afforded the opportunity to continue coverage based on whatever options the deceased participant qualified for. If the spouse remarries, the spouse is not entitled to this benefit.

Please note: This does not apply to participants covered under the Retired Disability Health Provision. (See section - Coverage After Disabled Member's Death on Page 12.)

DISABILITY HEALTH PROVISION

Eligible Disabled Participant

A disabled participant qualifies for benefits and is an eligible disabled participant under this Disability Health Provision if all of the following conditions are satisfied:

1. **Social Security Award Letter** – The individual has received a Social Security Disability Award Letter and presents the award to the Fund Office within 90 days of receipt of the letter;
2. **Active Coverage** – The individual has an "Active" level of coverage on the date the Social Security Disability Award Letter deems you disabled;
3. **15 Consecutive Years** – The individual has earned an "Active" level of coverage for benefits through the Health Fund for at least 15 consecutive years prior to the date of disablement;
4. **Pension** – The individual qualifies for, and is receiving, a Pension through the New Jersey Carpenters Fund; and
5. **Union Dues –** The individual's union dues are paid up to date with his or her Local Union.

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

Healthcare benefits are provided to you for the period of total disability or until the first day of the month preceding your 65th birthday, whichever occurs first. However, Medicare will take over as your primary coverage after two years from the date of your permanent disability.

MEDICARE ENROLLMENT

You must enroll in Medicare Part A and Part B in order to continue benefits through the Disability Health Provision. In addition, the Fund Office will enroll you in the Medicare Prescription Plan (Medicare Part D). Prior to your Medicare effective date, enrollment information will be sent to you.

Once you become eligible for Medicare coverage, the Disability Health Provision requires the participant pay a monthly premium for single or family coverage.

If your spouse is covered as an employee under a group plan with greater than 100 participants, that plan is primarily liable for the disabled member if your spouse has elected coverage for dependents.

All eligible dependents of the disabled member will also be eligible for benefits, provided the dependent was covered as an eligible dependent under the Health Fund on the participant's date of disability. Coordination of Benefits provision will apply with regard to any other benefit plans covering the dependent. Proof of disability, acceptable to the Trustees, must be submitted periodically upon request. The Trustees may require any member claiming such disability credits to submit to a physical by a physician designated by the Trustees. Upon attaining age 65, total disability coverage ceases and the participant covered under this provision will be covered under the Retired Health Plan if qualifications are met. The eligible spouse and dependent children of the disabled participant will also be eligible for the Retired Health Plan, provided they were covered as an eligible spouse/dependents under the Fund on the participant's date of disability.

If the member did not qualify for the Retired Health Plan, then COBRA will be offered.

Coverage After Disabled Member's Death

There is no Health Death Benefit for those individuals covered under the Disability Health Provision.

If the member dies while covered by the Disability Health Provision under the Retired Health Plan, the benefits for the eligible dependents will continue to the end of the month following 9 months from the date of death. Any monthly premium payments must be paid in order to continue coverage for the 9 month period. In no event will coverage for a member's dependents be continued if the dependents do not meet the definition of eligible dependents. At the end of this 9 month period, the Disability Health Provision ceases and, if qualifications are met, the dependents of the deceased member may elect coverage under the Retired Health Plan. If the member did not qualify for the Retired Health Plan, then the eligible dependents will be offered COBRA.

SUBROGATION AND REIMBURSEMENT

Benefits are not payable if an injury or illness occurs through the act or omission of another party, or if any other insurance policy (including but not limited to worker's compensation insurance, motor vehicle insurance or homeowner's insurance) is obligated to cover medical expenses associated with a participant or beneficiary's injury or illness. Every eligible retired participant, eligible dependent or service provider has an obligation to notify the Fund Office of any events, including items on the Notification List, (see pages 5-6), 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. 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 member, 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 10 days 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 30 days 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 Retired 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 Retired Health Plan will result in the Fund Office withholding the amounts due from future health benefit claims.

SIGN UP FOR MEDICARE PART A & PART B

If you or your spouse are 65 years of age or older, it is mandatory that you sign up for Medicare Part A and Medicare Part B. You must visit your local Social Security office or call Social Security at 1-800-772-1213 to sign up for Part A and Part B.

If you decide to wait to sign up for Part B when you are first eligible because you are covered under a group health plan based on current employment, you can sign up for Medicare during a special enrollment period. Usually you do not pay a late enrollment penalty if you sign up during a special enrollment period which is the 8 month period that begins the month after the employment ends (last employer contribution) or the group health plan coverage ends, whichever happens FIRST. Please note, if you are covered under this Retired Health Plan, you do not have coverage based on current employment.

It is your responsibility to sign up for Medicare Part A & B and provide the Fund Office with a copy of your Medicare card. In addition, the Fund Office will enroll you in the Medicare Prescription Plan (Medicare Part D). Prior to your effective enrollment date, information will be sent to you.

THE NJ CARPENTERS RETIRED HEALTH PLAN WILL NOT BE THE PRIMARY PAYER IF YOU FAIL TO SIGN UP FOR MEDICARE WHEN YOU ARE FIRST ELIGIBLE.

SELF-PAYMENT RULES

Monthly Premium Payments

Monthly premium payments for participation in the NJ Carpenters Retired Health Plan are due on the 1st day of every month. There is no billing invoice; it is your responsibility to make your premium payments to the Fund Office by the first of every month. Failure to pay your premium will result in your termination from the NJ Carpenters Retired Health Plan. Retired eligibility rules apply.

Waiving Benefit Coverage

If you are eligible for the Retired Health Plan and choose not to make a self-payment for medical coverage under this Plan because you have coverage through another group health plan, you may waive your coverage leaving the option open to come back into this Plan when your other health plan benefits have terminated. This request must be submitted in writing to the Fund Office along with a copy of your health benefits identification card. If your other group health benefits terminate, you must submit a copy of the benefit termination notice (Certificate of Creditable Coverage). At this time, you and your eligible dependents will be offered the retired health benefits that are currently available under this Plan.

Forfeiture of Rights

If you choose not to participate in the Retired Health Plan when you are first eligible, you forfeit your rights under the Retired Health Plan. You may not reinstate your Retired Health Plan benefits unless you previously waived your coverage according to the Plan guidelines stated above.

If you are making a self-payment in the Retired Health Plan and discontinue paying for any reason (with the exception of waiving benefit coverage) you will forfeit all your rights to participate in the Retired Health Plan.

Non-Medicare Payment (Both under 65 Years of Age)

If you are an eligible retired participant age 55 through 64 and are not eligible for Medicare, you may make a self-payment to the Retired Health Plan for yourself and your eligible dependents. This self-payment may be made until the month preceding you and/or your spouse's 65th birthday or until your dependents no longer qualify as eligible dependents. Payments must be made by the retiree in accordance with the guidelines set forth by the Board of Trustees.

Example of Non-Medicare Payment
(Both under 65 Years of Age with an eligible dependent child)

	Age	Level 1 Monthly Premium	Level 2 Monthly Premium
Member	61	$458.00*	$625.00*
Spouse	59		
Child	20 (full-time student)		

*Monthly Premium subject to change.
Single eligible retired participant pays same premium

Non-Medicare Payment (1 over 65 Years of Age / 1 under 65 Years of Age)

If you are an eligible retired participant in this category and you, or your spouse, are age 65 or older, you may make a self-payment to the Retired Health Plan for yourself and your eligible spouse. **The participant age 65 or older MUST be enrolled in Medicare Part A & B.** This self-payment may be made until the month preceding you and/or your spouse's 65th birthday. Payments must be made by the retiree in accordance with the guidelines set forth by the Board of Trustees.

Example of Non-Medicare Payment**
(One over 65 Years of Age, one under)

	Age	Level 1 Monthly Premium	Level 2 Monthly Premium
Member	66	$458.00*	$625.00*
Spouse	61		

*Monthly Premium subject to change.
**Retired Health Plan is primary payer for the Non-Medicare individual.
Medicare participant MUST enroll in Medicare Part A & B.

Medicare Retired Supplemental Payment
(Married - both over 65 Years of Age or Single over 65 Years of Age)

If you are an eligible retired participant age 65 or older, and your eligible spouse is age 65 or older, you may make a self-payment to the Retired Health Plan. **You and your eligible spouse must be enrolled in Medicare Part A and Medicare Part B.** Payments must be made by the retiree in accordance with the guidelines set forth by the Board of Trustees. Dependent children are not eligible for this coverage.

Example of Medicare Retired Supplement Payment
(Married - both over 65 Years of Age)

	Age	Monthly Premium
Member	67	$250.00*
Spouse	65	
Single Member	65	$125.00*

*Monthly Premium subject to change.

RETIRED NON-MEDICARE HEALTH PLAN BENEFITS

HEALTHCARE BENEFITS FOR RETIREES AND ELIGIBLE DEPENDENTS NOT ELIGIBLE FOR MEDICARE

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.

COORDINATION OF BENEFITS

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

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

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

- When a person is covered as an employee under one group contract, and as a dependent under another, then the employee's coverage pays first.

- Where a primary plan covers the patient under an HMO or other closed network, failure to obtain treatment within that network will result in a reduced payment by the New Jersey Carpenters Retired Health Plan (up to a maximum of 50% of our fee schedule).

- When the spouse of an eligible retired participant is currently working and is covered under another group health insurance plan, that plan is primarily liable for the spouse and eligible dependents.

- 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 of Payment When More than One Group Insurance Covers a Dependent Child:

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

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

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

- If the 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. the stepparent) pays second, and
3. the plan of the parent without custody pays last.

Stepchildren of a member who do not reside with the member are not eligible for benefits.

The New Jersey Carpenters Retired Health Plan will provide its regular benefits in full when it is the primarily liable plan. When this Plan is secondarily liable, it will provide a reduced amount which when added to the benefits of the other group plan, will not exceed 100% of the charges for the patient's eligible expenses covered under at least one plan, 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.

LEVEL 1 BENEFITS
Hospital/Surgical

PRE-CERTIFICATION PROGRAM

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

Failure to pre-certify your hospital admission 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, doctor's office, surgical center), is medically appropriate for your condition and they may suggest other available alternatives.

If you decide to enter the hospital as an inpatient after receiving a denial, you may be liable for all or a portion of the eligible 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 the Retired Health 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 Retired Health Plan to pay said costs shall be limited to the amount that the Retired Health Plan would have paid to an in-network hospital/facility. Any charges above our fee schedule will be the member's responsibility. Contact our Provider Relations Department for in-network hospitals/facilities or the telephone number listed on the back of your medical identification card.

CASE MANAGEMENT PROGRAM/UTILIZATION

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

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

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

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

HOSPITAL BENEFITS

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

Days of Care Available – Benefits are provided for you and each of your enrolled dependents for up to 150 days of inpatient care in an acute or sub-acute care hospital in a lifetime. Same day surgery is equivalent to one day of inpatient care towards your 150 day maximum. All medical expenses incurred in the hospital after your 150 day hospital limit is reached are also ineligible for reimbursement by this Fund until your hospital benefit days are reinstated.

Renewal of Benefits Days – The number of benefit days for inpatient care will renew, in full, when 12 months have passed from the date of last discharge from a hospital, regardless of whether or not the Fund Office made any payments.

Hospital Inpatient Care in Semi-Private Accommodations – If an injury or illness, including pregnancy related conditions for a participant or enrolled spouse, makes hospitalization medically necessary, bed and board, including special diets and general nursing care, are covered in full, up to the Plan limitations, 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 in full, 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 - $100 co-payment applies, waived if admitted. 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. 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 covered.

3. Immediate medical attention must be sought. If there is a significant time lapse between the onset of symptoms or an injury and the time that you seek medical treatment, the claim will not be considered an emergency.
4. Immediate care is medically necessary.

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

If benefits are classified as non-emergent, claims will be eligible only under the Major Medical 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. Pre-certifying may 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. Each day of eligible outpatient care from a surgicenter is counted as one day towards your available inpatient acute/sub-acute care hospital days.

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 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.

Substance Abuse (Drug and Alcohol) Benefit Limit – Limited to two inpatient admissions per individual per lifetime. All admissions must be pre-approved by the Fund Office.

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, or;**
- **To determine eligible services under the Retired Health Plan.**

IN-HOSPITAL MEDICAL CARE

- **Days Available** - You are entitled to one physician visit per day to render medical (non-surgical) care up to a maximum of 150 days.
- **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 capulitis of shoulder or arthrofibrosis of the knee when performed by an orthopedic surgeon only. MUA for any other reason is not a covered benefit.

ELECTRIC SHOCK WAVE THERAPY (ESWT) – Benefits for ESWT are eligible for plantar fasciitis and lateral epicondylitis only. This procedure must be pre-approved by the Fund Office and meet medically necessary criteria. Criteria 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 provided up to our fee schedule in a hospital for the services of an assistant surgeon 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. If possible, contact the Fund Office for participating providers to minimize your out-of-pocket expense.

MATERNITY AND 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 participants or for the enrolled spouse of any participant up to a family lifetime maximum of $250,000.00. **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. In such cases, the maximum maternity benefit applies until the date of discharge.

- **High Risk Pregnancy** – If any medication, equipment, etc. is needed for high risk pregnancies, the nurse case managers must be notified. Maximum maternity benefits apply.

- **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. Maximum maternity benefits apply and charges will be paid to our fee schedule only.

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

DIAGNOSTIC X-RAY AND 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 for x-rays and laboratory tests in connection with care of teeth.

COSMETIC/PLASTIC SURGERY – Benefits are not provided 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**
- **Prosthesis 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 NJ Carpenters Health Fund at 1-800-624-3096.

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 Benefits and subject to the limits therein. Please refer to the Major Medical Benefits section. 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 be pre-certified by the Fund Office. 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, freestanding 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 dental condition must be pre-approved by the Fund Office.

Medical-Surgical and or Major Medical 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. There is a lifetime limit of one transplant per person, with a benefit maximum of $250,000.00 which includes all eligible pre and post operative services, supplies and drugs related to the transplant procedure. Services, supplies, and drugs that are not normally eligible are still excluded, (i.e. non-FDA approved drugs or supplies and non-AMA approved services or procedures for the diagnosis). If Medicare is your primary insurance, transplant services must be rendered at a Medicare approved facility in order for benefits to be coordinated.

LEVEL 2 BENEFITS
Major Medical / Prescriptions

MAJOR MEDICAL

Co-Payment - $10 co-payment for all office visits when using participating providers. Contact the Fund Office for participating providers or log onto to www.njcf.org.

Deductible – The first $200.00 of the allowable expenses covered under your Major Medical 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.

Maximum Benefits – An individual lifetime maximum of $250,000.00 is available to you and each of your covered dependents while you are covered for Major Medical benefits. 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). There is a $5,000.00 annual threshold for each individual. After you reach the $5,000.00, the Plan will pay 100% of our fee schedule for eligible medical expenses up to a lifetime maximum of $250,000.00.

Reinstatement of Benefits – Each year on April 1st, each covered person who then has benefits from the previous benefit period charged against their lifetime maximum will have the lesser of payments made or $1,000.00 restored automatically for future use.

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 adjusted periodically to provide fair and reasonable reimbursement by the Retired Health Plan.

The following services are Eligible Major Medical Expenses:

- Physician office visits/consultations.
- 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 required for therapeutic use, or purchase of such equipment if the cost would be less than the rental. For more information, see the section on Durable Medical Equipment.
- One routine physical examination per benefit year, including required school physicals, gynecological examinations and pap smears.
- Immunizations provided by a licensed physician.
- Ultra Violet Light Therapy limited to 3 visits per week.
- Orthopedic shoes, when medically necessary, one pair per benefit year payable at 80% of our fee schedule, no deductible.

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.**

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

Custom Orthotics – 1 pair every three years

C-Pap Equipment – Replacement of mask and tubing every 6 months

TENS Unit Supplies – Replacement leads
2 lead – 1 pair per month
4 lead – 2 pair per month
Both units- replacement wires once a year

T.E.D. Stockings – Limited to compression greater than 30mm Hg and less than 50mm Hg. along with valid prescription. (2 pair every 6 months)

PLEASE NOTE: It is your responsibility to call the Fund Office to make sure any DME equipment you are receiving is with a participating provider to avoid any out-of-pocket costs. All 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.

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

Physical Therapy – Physical Therapy is a covered benefit for an acute illness or injury only. A valid prescription from your physician is required. All participating providers will only be reimbursed up to our fee schedule. All 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 year.

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 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 year.

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. ($1,200.00 family maximum still applies.) All services must be provided by a licensed Doctor of Chiropractics (D.C.). All eligible services that are approved will be counted toward the $1,200.00 annual family maximum.

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

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

Behavioral Health – Charges for psychotherapy and medication management are payable at 80% of our fee schedule. To minimize your out-of-pocket expense, contact the Fund Office or search the web-site at **www.njcf.org** for participating providers. Pre-approval is needed for all treatment with a participating provider. Psychotherapy is covered when provided by a licensed mental health professional (including 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.

All psychological or 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.

NON-MEDICARE PRESCRIPTION DRUG BENEFIT

The prescription drug benefit is included as a part of your Major Medical benefit, subject to the individual lifetime maximum of $250,000.00. The prescription drug benefit is capped at $50,000.00 per year per family. 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 program. The following prescriptions are not covered. Please contact the Fund Office for additional exclusions.

- **PRESCRIPTION DRUGS USED FOR THE TREATMENT OF INFERTILITY ARE NOT COVERED.**
- **NON-SEDATING ANTIHISTAMINES (ALLERGY) DRUGS ARE NOT COVERED.**

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

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

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

- **Brand Name Drugs: $10.00 or 20% whichever is greater of the prescription cost for up to a 30-day supply when there is no generic available.**
- **Generic Drugs: $5.00 for up to a 30-day supply.**
- **Specialty and/or Injectable Drugs: 20% co-payment.**

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

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

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

- **If you are taking any maintenance medication, you will be required to fill it through the Medco Mail Order pharmacy.**
- **If you fill a maintenance medication at a retail pharmacy, you will pay the normal retail co-payment. However, after the third time you refill 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.**

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

Prilosec OTC Program (PPI class of Drugs)

The New Jersey Carpenters Retired Health Plan covers Prilosec OTC at 100% when filled at a participating retail pharmacy with a valid prescription from your doctor. Therefore, you will have no co-payment. Prilosec OTC is not available through the Mail Order Program. It is the only medication where a 90-day supply is authorized at a retail pharmacy. However, should you choose to elect any other PPI drugs (such as but not limited to Neximum, Prevacid, Protonics, Aciphex, Omeprazole, and Zegerid), you will be charged a 40% co-payment.

Medco Claim Forms

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

LIMITATIONS

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 Retired Health Plan. 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 Hospital and Medical-Surgical Benefits (excluding services provided by acute, sub-acute, or skilled nursing rehabilitation facilities) will be eligible for coverage under the New Jersey Carpenters Retired Health Plan. No Major Medical benefits will be eligible for reimbursement (i.e. follow-up office visits, physical therapy, rehabilitation facilities (acute or sub-acute), prescription drugs, durable medical equipment).

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

4. Organ/bone marrow transplants are limited to one transplant per person, per lifetime with a benefit maximum of $250,000.00 which includes all eligible pre and post operative services, supplies and drugs related to the transplant procedure. Services, supplies and drugs that are not normally eligible are still excluded, i.e. Non-FDA approved drugs or supplies and Non-AMA approved services or procedures for the diagnosis.

5. Hospital and medical services for any condition related to pregnancy including childbirth, newborn care, abortion or miscarriage are covered for enrolled female participants or for the enrolled spouse of any participant up to a family lifetime maximum of $250,000.00. Obstetrical care is not available to dependent children.

6. Major Medical Benefits are limited to an individual lifetime maximum of $250,000.00. Other benefit limitations apply, such as but not limited to, physical therapy, chiropractic care, psychotherapy and acupuncture. (See Major Medical Benefits section)

7. Prescription drug benefit is limited to $50,000.00 per family per benefit year.

EXCLUSIONS

You are NOT covered for:

1. Services that are eligible for payment under any other insurance. (i.e. Medicare, automobile 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.

10. Experimental, educational, investigational or ineffective procedures or treatments.

11. Services made necessary by a disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.

12. Services rendered or supplies provided prior to the covered person's effective date, or after coverage is ended for any reason unless specifically provided for in this booklet.

13. Charges which are in excess of our fee schedule.

14. Charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim or medical history form.

15. Personal services such as haircuts, shampoos and sets, guest meals and radio/telephone/television/VCR/DVD/tape rentals or internet services.

16. Durable medical equipment and personal convenience items which are primarily for comfort and convenience rather than a medical purpose, including but not limited to: air conditioners, humidifiers, purifiers, physical fitness equipment, heating pads, jacuzzis, whirlpools, tanning beds and similar supplies which are useful to a person in the absence of illness or injury.

17. Charges incurred during a covered person's temporary absence from the eligible provider's facility before discharge.

18. Services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations.

19. Dietary or nutritional counseling for behavior modification classes or weight loss programs or food supplements (i.e. "Optifast", "Nutrisystem", "Weight Watchers", etc.).

20. Services for treatment of obesity unless the criteria for gastric bypass/lapband surgery is met.

21. Routine or periodic physical examinations, testing and immunizations which by law are required for employment. Including 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 guideline. Charges or supplies which any school system or township provides on a discretionary basis upon application, other form, or requested 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 medications which were not medically necessary.
27. Treatment of sexual dysfunction, including but not limited to erectile dysfunction and insertion of penile implants and pumps.
28. Treatment leading to or in connection with transsexual surgery including prescription drugs.
29. Fertility treatments and associated prescription drugs including all surgical procedures and testing, including but not limited to: ovarian transplants, in vitro fertilization, zift, gift, and any assisted reproductive technology (ART).
30. Any claims pertaining to surrogate pregnancy, including delivery or any complications arising thereof.
31. Reversal of sterilization procedures under any circumstance.
32. Services and supplies for any condition related to the pregnancy of a dependent child.
33. Care in nursing home or home for the aged.
34. Custodial care such as sitters, homemaker's service, home health aide or care in a place that serves you primarily as a residence.
35. Services or supplies in connection with any procedure or examination not incident to or necessary for diagnosis of any injury or sickness for which bonafide provisional diagnosis has been made because of existing symptoms.
36. Services or supplies not listed as Eligible Medical Expenses.

37. Convalescent, custodial or sanitorium care or rest cures.

38. Exercise programs for treatment of any condition including membership fees for fitness centers (i.e. Health Spas, YMCA).

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, such as 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 (i.e intensive out-patient 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.

MEDICARE RETIRED SUPPLEMENTAL PLAN

This benefit is provided for the eligible retired participant and the eligible spouse. It pays all Medicare deductibles including Part A and Part B and 20% of all Medicare approved charges. The Medicare Retired Supplemental Plan is only available to offset medical expenses covered by Medicare Part A and Part B when the covered individual incurs a medical liability.

Charges not approved by Medicare are ineligible under the limits of the Medicare Retired Supplemental Plan. To find out if Medicare covers a service, contact Medicare at 1-800-633-4227 or on-line at www.medicare.gov. Ask your doctor or supplier in advance if they accept Medicare assignment. If you use a provider who has "opted out" of Medicare, you will have to pay the full amount of whatever this provider charges for the services rendered. No reimbursement will be made by the Fund Office.

Exclusions:

Services not covered by Medicare are not eligible under the Retired Health Plan Benefits.

Listed below are some items and services not covered by Medicare, such as, but not limited to:

- Long-term care
- Dental care
- Cosmetic surgery
- Acupuncture
- Hearing aids
- Exams for fitting hearing aids
- Orthotics
- Healthcare needs when traveling outside the United States
- Laboratory testing not approved by Medicare

For a complete list of exclusions contact 1-800-633-4227 or visit www.medicare.gov.

MEDICARE PRESCRIPTION DRUG BENEFIT

Eligible Retired Participants and their eligible spouse participating in the Medicare Retired Supplemental Plan will be enrolled in a Medicare Part D plan administered by Medco. This plan is a fully insured Medicare Part D prescription drug program administered by Medco and is therefore subject to all rules and regulations of Medicare Part D programs.

Medco Medicare Part D Plan Highlights:

- **$0 Deductible**
- **Generic Drug Coverage in the "Donut Hole"/Coverage Gap**
- **Coverage of prescription drugs while in Nursing Homes and Residential Facilities *(31-Day Supply Limit)***
- **No Annual Benefit Cap**

Retail Pharmacy Co-payments (subject to change):

Tier 1: Generic Drugs

- $10 co-payment for a one-month (34-day) supply of drugs
- $20 co-payment for a two-month (60-day) supply of drugs
- $30 co-payment for a three-month (90-day) supply of drugs

Tier 2: Preferred Brand Drugs

- $30 co-payment for a one-month (34-day) supply of drugs
- $60 co-payment for a two-month (60-day) supply of drugs
- $90 co-payment for a three-month (90-day) supply of drugs

Tier 3: Non-Preferred Brand Drugs

- $50 co-payment for a one-month (34-day) supply of drugs
- $100 co-payment for a two-month (60-day) supply of drugs
- $150 co-payment for a three-month (90-day) supply of drugs

Mail Order Pharmacy Co-payments (subject to change):

Tier 1: Generic Drugs

- $25 co-payment for a three-month (90-day) supply of drugs

Tier 2: Preferred Brand Drugs

- $75 co-payment for a three-month (90-day) supply of drugs

Tier 3: Non-Preferred Brand Drugs

- $125 co-payment for a three-month (90-day) supply of drugs

There may be isolated instances when you can purchase the medication for less when using your own senior citizen discount coupled with a sales or promotional campaign that a particular pharmacy may be running. It is recommended that you determine and compare the final costs of your prescriptions before making your co-payment.

RETIREES RECEIVING CARE AT A VETERANS AFFAIRS MEDICAL FACILITY

If you receive medical care or treatment at a Veterans Affairs medical facility, the Fund's liability is secondary. Our payment as the secondary carrier will not exceed 20% of the Medicare allowable fees. Payment will be made directly to the Department of Veterans Affairs or applicable facility. Prescription drug co-payments from the VA are not eligible for reimbursement.

ASSIGNMENT OF BENEFITS

The Health Fund's liability with respect to claim reimbursement and release of information is to you, a working or retired carpenter, or your eligible dependents. When reimbursement is made to you, you have a legal obligation to pay all medical bills.

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

COBRA 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".

Qualifying Event - Any of the following events qualifies for continuation of coverage if the event results in loss of coverage:

Non-Eligible Retired Participant

Non-Eligible Participants who do not qualify for the Retired Health Plan, but have been afforded coverage under this Plan, based on current contributions and/or banked credits, will be offered COBRA continuation coverage for up to 18 months after all credits and contributions are exhausted.

For Spouses

- Re-marriage after death of a Retired Participant
- Divorce or legal separation from your spouse

For Dependent Children

- Death of a covered parent
- Divorce or legal separation of your parents
- The dependent no longer meets the definition of a "dependent child" as defined under the Retired Health Plan

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. The participant and the dependents have the responsibility to send notice to the Fund Office when any one or more of the following events occur:

- The death of a member
- A divorce or a legal separation
- A child losing dependent status

Notification by the participant or 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. 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 that 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 Fund Office 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 retiree's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

Continuation coverage can end before the 36 month limitation for any of the following reasons:

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

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

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 can get access to this information. Please review it carefully.

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"), and describes and informs you about:

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/Healthcare 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 above, 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.

We 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. These 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; and**
- **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 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 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 AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

The Board of Trustees agrees to:

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

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

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

CERTIFICATES OF CREDITABLE COVERAGE

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

The Certificate of Creditable Coverage will be provided to you:

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

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

CLAIMS, DENIALS AND APPEALS

Notice Of Denial

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

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

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

In the case of a pre-service claim, the Plan Administrator shall notify you of the Fund's benefit determination (whether adverse or not) within a

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

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

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

medical circumstances, or a statement that such explanation will be provided free of charge upon request. If the denial concerns a claim involving urgent care, the notice will describe the expedited review process applicable to such claims.

Appeal Of Denied Claims

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

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

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

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

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

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

Appeals should be submitted within 12 months of the date you were notified of the action taken to deny all or part of your claim. Upon receipt of the inquiry, your claim will be researched and reviewed thoroughly. Such review shall take into account all comments, documents, records

and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

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

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

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

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

The Plan Administrator shall provide you with written notification of the Fund's benefit determination on review. In the event your appeal is denied, the written notice of the denial of the appeal shall: (a) set forth the specific reason or reasons for the denial; (b) refer to the specific Plan provisions on which the denial is based; (c) state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; (d) describe your right to bring a civil action under section 502(a) of ERISA. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, the notice shall include either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in reaching the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. Moreover, if the denial is based on a medical necessity or

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

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

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

(1) A complete list of the employer and employee organizations sponsoring the Plan, which list is available for examination by participants and beneficiaries;

(2) Information as to whether a particular employer or employee organization is a sponsor of the Plan, and if it is, the sponsor's address.

YOUR RIGHTS UNDER ERISA

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

(a) Examine, without charge, at the Fund Office and at other required locations such as union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. There will be a minimum charge of $25.00. If the number of pages exceeds 25 pages, there will be an additional charge of $1.00 per page;

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

(e) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a Certificate of Creditable Coverage, free of charge, from your group health plan or health 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.

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.

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AFFILIATED GROUPS
EMPLOYEE GROUPS

NORTHEAST REGIONAL COUNCIL OF CARPENTERS

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

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

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

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

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

LOCAL UNION #715
Millwrights

LOCAL UNION #39
Tapers

AFFILIATED GROUPS
EMPLOYERS GROUPS

Building Contractors Association of New Jersey

Associated General Contractors of New Jersey

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

MERGER DATES

L.U. 2212 - January 1, 1998
L.U. 31 - January 1, 1999
L.U. 1342 - January 1, 1999
L.U. 6 - January 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 disbursal of all the assets of the Fund, the Plan and Fund will terminate.

-NOTES-