NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND

SUMMARY PLAN DESCRIPTION

Effective January 1, 2013

TO ALL PLAN PARTICIPANTS:

This Summary Plan Description (SPD) has been prepared to provide you with details of the Plan available through the North Central States Regional Council of Carpenters' Health Fund for Construction Carpenters, Millwrights, Non-Bargaining Unit Employees, and Industrial Employees effective January 1, 2013. This SPD describes the coverages available, how you qualify for them, and under what circumstances you may not be eligible. It also tells you how to file a claim for benefits and what action you can take if you are denied benefits.

Benefits under the North Central States Regional Council of Carpenters' Health Fund (Health Fund or Fund) are not vested or guaranteed. This booklet is a summary. The exact provisions of the benefits and Eligibility Rules are set forth in the North Central States Regional Council of Carpenters' Health Fund Plan Document (Plan or Plan Document). Only the Plan Document establishes the legal rights, privileges, and obligations under the Health Fund. No summary can give you all the details. This general explanation does not change or expand or otherwise interpret the terms of the Plan Document or Trust Agreement in any way. If there should be any conflicts or inconsistencies between this summary and the actual provisions of the Plan Document and Trust Agreement, the Plan Document and Trust language will govern.

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

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

The Eligibility Rules and benefits are maintained at levels in line with Trust Fund income and assets; they are reviewed regularly to provide the best protection possible within the Fund's financial means. Benefits payable are limited to Fund assets available for such purposes. All Plan provisions are updated regularly to comply with current applicable federal laws. All benefit changes since May 1, 2002, are incorporated in this booklet.

Please read this entire SPD carefully so that you will know the benefits to which you and your family are entitled. Pay special attention to the preauthorization and precertification requirements described on pages xviii through xx to qualify for maximum benefits. Also, take advantage of the preferred providers described on pages 46 through 50 which offer you reduced rates on covered services and supplies.

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

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

Sincerely,

BOARD OF TRUSTEES

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Fund Office
Kristin Passineau, Administrative Manager
North Central States Regional Council of Carpenters' Health Fund
1704 Devney Drive, Altoona, WI 54720
Mailing Address: P.O. Box 4002, Eau Claire, WI 54702

Telephone

Eau Claire Area..... (715) 835-3174
Nationwide ..... (800) 424-3405
Inpatient Precertification..... (800) 861-8744

Facsimile

Claims Department ..... (715) 835-3114
Fund Office..... (715) 834-8061

Fund's Website: www.ncscbf.com

Office Hours: Monday-Friday 8 a.m. - 5 p.m.
(excluding holidays)

Fund Legal Co-Counsel

Scott H. Engroff, LLC
Suite 111
Coventry Office Building
250 West Coventry Court
Milwaukee, WI 53217

The Previant Law Firm S.C.
1555 North RiverCenter Drive, Suite 202
Milwaukee, WI 53212

Fund Certified Public Accountant

CliftonLarsonAllen LLP
220 South Sixth Street, Suite 300
Minneapolis, MN 55402

Fund Consultant

Lee Jost and Associates
One Park Plaza
11270 West Park Place, Suite 950
Milwaukee, WI 53224

SCHEDULE OF BENEFITS

Classes C and O For Active Employees and Dependents		
COMPREHENSIVE MAJOR MEDICAL BENEFITS		
	PPO/POS Network Provider	**Non-PPO/POS Network Provider**
Deductible Amount[1,2,3] Per person per calendar year Per family per calendar year	 $200 $600	 $ 400 $1,200
Plan's Copayment of Covered Charges[3,4]	90%	70%
Out-of-Pocket Maximum for Covered Charges per calendar year, including the deductible and copayment amounts[2,3,4] Plan pays 100% of covered charges in excess of such maximum for such persons for remainder of that calendar year, up to the calendar year maximum for essential health benefits, unless otherwise specified.	$1,500 per person or $4,500 per family	$2,500 per person or $7,500 per family
Calendar Year Maximum Per Person for Essential Health Benefits (including prescription drugs purchased through the PPRx)	$2,000,000[5]	
Comprehensive Major Medical Benefits cover expenses related to hospital services, physicians' services, x-ray and laboratory services, prescribed drugs and medicines (excluding those covered through PPRx), and other covered items and services when medically necessary. Amounts in excess of all maximums are the liability of the eligible person.		

[1] The deductible amount will be waived for the alternative ways of obtaining care and preventive care (see pages 37-41).

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

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

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

[5] $2,000,000 maximum effective for the 2013 calendar year for essential health benefits only.

Classes C and O
For Active Employees and Dependents

COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)

There is a separate copayment of $50 for each hospital emergency room visit which does not apply toward satisfaction of the deductible or out-of-pocket maximum. This copayment is waived when admitted to the hospital as inpatient or for observation.

Maximum payment per outpatient chiropractic visit: $40.

Maximum for acupuncture services is $500 per person per calendar year.

Preventive care:
In-network services (as listed on pages 37 and 38) payable at 100% of reasonable expenses, no deductible, no calendar year maximum.
Out-of-network services (or in-network services not specified in listing on pages 37 and 38) payable as follows --

Routine physical examinations, 100% of reasonable expenses up to aggregate maximum of $531 for each employee or spouse per calendar year. Routine physical exam charges in excess of the $531 maximum are payable at 20%. Your copayment is not applied to out-of-pocket maximum.

Well child care, 100% of reasonable expenses for: routine examinations and laboratory tests recommended by the American Academy of Pediatrics from birth to age two; and up to $200 per person per calendar year for dependent children ages two and over. Well child care charges in excess of the $200 maximum are payable at 20%. Your copayment is not applied to out-of-pocket maximum.

Routine colonoscopy and electrocardiograms (EKG), 90% of reasonable expenses, no deductible, no calendar year maximum.

Routine immunizations (limited to those specified on page 37), 100% of reasonable expenses.

The deductible and copayment amounts are waived for covered charges related to the following services. The Plan pays 100% of the reasonable expenses incurred for such covered charges, up to the calendar year maximum:

1. Hospice Care (preauthorization recommended for home hospice and precertification required for hospice care in a hospice facility).

2. Home Health Care (preauthorization recommended).

3. Skilled Nursing Facility Care: up to 30 days of confinement per period of disability (precertification required).

Classes C and O For Active Employees and Dependents	
COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)	
Infertility testing	Lifetime maximum of $4,000 per each employee and dependent spouse **NOTE: Treatment of infertility is not covered.**
Vision therapy	$4,000 lifetime maximum per person
Temporomandibular joint disease (TMJ) treatment, including diagnostic tests and therapy but not surgery	$1,000 maximum per person per calendar year
Morbid obesity treatment, including physicians' services, lab work, and patient education in a medical setting	$500 lifetime maximum per person
Non-prescription drugs upon a physician's written prescription (excluding those OTC drugs covered under the PPRx as specified on page ix)	$50 maximum per person per calendar year
Wigs and toupees	$300 lifetime maximum per person
Hearing aids	Maximum one per ear every three calendar years up to $750 per aid
Hearing exams	One exam every three years
Experimental medical treatment and procedures (preauthorization recommended)	$5,000 aggregate maximum per disability
CPAP, BiPAP, and AutoPAP supplies (preauthorization recommended)	$200 maximum per person per calendar year
Genetic testing (preauthorization recommended)	$1,500 lifetime maximum per person
Hospital admission kits	$30 maximum per admission

Classes C and O For Active Employees and Dependents	
COMPREHENSIVE MAJOR MEDICAL BENEFITS (continued)	
Organ Transplants	
Benefits self-funded by North Central States Regional Council of Carpenters' Health Fund[1]:	
Covered services for hospital, surgical, and medical expenses and for postoperative immunosuppressant drug therapy	Payable under the Plan the same as for any other disability
Donor-related services maximum	$25,000
Insured Benefits insured through insurance carrier for all other approved transplant surgeries:	
Donor(s) services (procurement only)	100% of reasonable expenses, up to organ transplant insurance lifetime maximum
Maximum daily limit for lodging and meals	$200 per day
Aggregate maximum for transportation, lodging, and meals	$10,000 of reasonable expenses per transplant benefit period
Private nursing care	100% of reasonable expenses, up to organ transplant insurance lifetime maximum
All other covered services	100% of reasonable expenses, up to aggregate organ transplant insurance lifetime maximum of $2,000,000 per lifetime[2,3]

[1] Cornea transplants are self-funded.

[2] If you choose not to use a transplant network facility, benefits are payable at 80% to a maximum dollar amount specified in the insurance policy.

[3] Reasonable expenses for insured organ transplants in excess of such lifetime maximum are payable under Comprehensive Major Medical Benefits provisions.

Classes C, G, O, P, S, and T For Active and Optional Retiree Classes	
VISION CARE BENEFITS	
Plan's copayment Aggregate maximum per person each two consecutive calendar years (current two-year benefit period is 2012-2013)[1] *Please Note: Trustees have a Preferred Provider Agreement in effect with ShopKo Optical for covered eyewear and contact lens purchases (but excluding eye examinations). See page 49.*	90% $400
DENTAL CARE BENEFITS	
Deductible per person per calendar year (not applicable to orthodontic benefits)	$25
Plan's copayment of reasonable expenses (not applicable to orthodontic benefits)	90%
Maximum aggregate amount for preventive, restorative, prosthetic, and oral surgical care per person per calendar year[2]	$1,200
Orthodontic benefits Plan's copayment Lifetime maximum amount per person	 100% $2,000

[1] For dependent children under age 18, one vision exam every two calendar years will not be subject to the aggregate maximum.

[2] For dependent children under age 18, the following preventive dental services will be payable subject to the deductible and copayment, but will not be subject to the calendar year maximum: routine dental examinations, limited to two exams per person per calendar year, including bitewing x-rays once each calendar year; dental prophylaxis, limited to two per person per calendar year; topical fluoride applications, limited to two applications per person per calendar year; dental sealant applications; and full-mouth x-rays once every five years in lieu of bitewings.

Classes C, E, G, O, P, R, S, T, U, and V For Active and Retiree Classes	
PREFERRED PROVIDER PHARMACY PROGRAM[1,2]	
Retail	
Eligible person's copayment per covered prescription for up to a 30-day supply	
Generic	$8.00
Brand name (including multi-source brand name contraceptives)	The greater of $15.00 or 25% of the cost, to a maximum of $35.00 per prescription
Mail-Service	
Eligible person's copayment per covered prescription for up to a 90-day supply	
Generic	$16.00
Brand name (including multi-source brand name contraceptives)	The greater of $30.00 or 25% of the cost, to a maximum of $70.00 per prescription
Specialty Medications (through Specialty Pharmacy)	
Eligible person's copayment per prescription for up to a 30-day supply	25% of the cost, to a maximum of $50.00 per prescription
HEALTH DYNAMICS PREFERRED PROVIDER PREVENTIVE CARE PROGRAM (In lieu of routine physical examination benefits)	
For Employees and Dependent Spouses Only	Covered services payable in full

[1] Prescription drugs purchased through the PPRx are subject to the Comprehensive Major Medical Benefits calendar year maximum for essential health benefits.

[2] The following are covered at a $0.00 copayment through both retail and the mail-service PPRx upon a physician's written prescription: OTC aspirin; smoking cessation products, including OTC nicotine replacement therapy and federal legend drugs (up to one 90-day supply per 365-day period); federal legend fluoride; OTC iron supplements; and OTC folic acid as specified on pages 47 and 48; and generic and single-source brand name contraceptives for women as specified on page 47.

Classes C and O For Active Employees Only	
DEATH BENEFITS	
Amount of Death Benefit	$20,000
Principal Sum for Accidental Death and Dismemberment	$20,000
ACCIDENT AND SICKNESS WEEKLY BENEFITS	
Weekly benefit rate	$240
Maximum number of weeks payable per disability	16
Accident and Sickness Weekly Benefits are limited to 10 days per eligible employee per calendar year for treatment of nervous and mental disorders while hospital-confined and 30 days per each eligible employee's lifetime for treatment of alcoholism and substance abuse while hospital-confined.	
Benefits begin on the first day of a disability caused by an injury and on the eighth day of a disability caused by a sickness.	

SCHEDULE OF BENEFITS

For Retired Employees and Dependents and Surviving Spouses	
The benefit provisions and amounts for Classes P, R, S, T, U, and V are identical to Class C, with the following exceptions:	
COMPREHENSIVE MAJOR MEDICAL BENEFITS Organ Transplants	 All Medicare-approved transplants are self-funded for Medicare-eligible persons in Classes S, T, U, and V, subject to the self-funded provisions on page 33.
VISION CARE BENEFITS	Classes P, S, and T only[1]
DENTAL CARE BENEFITS	Classes P, S, and T only[1]
DEATH BENEFITS (Employees Only) Amount of Death Benefit Principal Sum for Accidental Death and Dismemberment	 $4,000 $4,000
ACCIDENT AND SICKNESS WEEKLY BENEFITS	No Coverage

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

SCHEDULE OF BENEFITS

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

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

SCHEDULE OF BENEFITS

Reduced Plan Option For Employees and Dependents Continuing Coverage Under Self-Payment Option 1 When Completely or Partially Unemployed in the Fund's Jurisdiction		
The benefit provisions and amounts for this Reduced Plan Option are identical to Class C, with the following exceptions:		
COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS	**PPO/POS Network Provider**	**Non-PPO/POS Network Provider**
Deductible amount		
Per person per calendar year	$1,000	$2,000
Per family per calendar year	$3,000	$6,000
Plan's copayment of covered charges	75% of preferred provider's negotiated charges	55% of reasonable expenses
Out-of-pocket maximum for covered charges per calendar year, including the deductible and copayment amounts	$5,000 per person or $15,000 per family	$10,000 per person or $30,000 per family
VISION CARE BENEFITS	No Coverage	
DENTAL CARE BENEFITS	No Coverage	
DEATH BENEFITS	No Coverage	
ACCIDENT AND SICKNESS WEEKLY BENEFITS	No Coverage	

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PREAUTHORIZATION AND PRECERTIFICATION REQUIREMENTS

FOR ALL CLASSES OF ELIGIBLE PERSONS

PREAUTHORIZATION

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

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

Home Services:

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

Outpatient Procedures:

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

Therapies:

- Physical therapy and occupational therapy after the initial evaluation and eight sessions.

Treatments:

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

Transportation:

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

Diagnostics:

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

Durable Medical Equipment (DME):

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

If you do not obtain preauthorization for these services and supplies and it is determined that they are not medically necessary, Plan benefits will be denied.

PRECERTIFICATION

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

Inpatient Admissions (non-emergency):

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

Observation Stays:

- All hospital observation stays that are over 23 hours.

(Preauthorization is recommended for certain outpatient surgeries as stated on page xvii.)

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

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

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

2. names, addresses, and telephone numbers of the physician and hospital;

3. reason for the hospitalization or surgery;

4. planned admission date, if applicable; and

5. name and identification number of the eligible employee.

Once CMS has received this information, they will contact your physician to discuss the injury or sickness and the proposed treatment plan.

After this contact, your physician will establish the appropriate length of time if you will need to stay in the hospital. This is done to ensure you receive the level of care medically necessary for the treatment of the injury or sickness involved. In some instances, it may be recommended that you receive a second opinion.

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

ELIGIBILITY RULES

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

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

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

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

These Rules apply to Industrial Employers who are obligated to make payments to the North Central States Regional Council of Carpenters' Health Fund (the Fund) under a collective bargaining agreement with a union participating in the Fund. If such Industrial Employer wishes to cover its non-bargaining unit employees, it must enter into a participation agreement. Eligibility of such employers' bargaining unit and non-bargaining unit employees will be in accordance with the terms of the participation agreement and subject to the following eligibility requirements.

If you are working full-time for the employer on the effective date of the employer's participation, you are eligible for coverage on the first day of the calendar month for which contributions are received by the Fund in behalf of such employees. If you are hired by the employer after the effective date of participation, you are eligible for coverage the first day of the calendar month following your date of hire. You remain eligible for coverage for as long as employer payments are received on time in your behalf under the terms of the collective bargaining agreement and the participation agreement. Your spouse and each of your dependent children are eligible for coverage under this Plan on the date he or she first satisfies the definition of dependent.

Only the following sections of these Eligibility Rules apply to Class O: COBRA continuation coverage (which is the only self-payment option for Class O), termination of coverage, coverage for employees and their dependents when employee enters service in the uniformed services, coverage while on Family and Medical Leave, change of Eligibility Rules,

conformity with Internal Revenue Code, and special enrollment periods. In addition, upon retirement, Class O employees will be permitted to continue coverage under the Retiree Program by making self-payments, provided such employees satisfy the eligibility requirements for such Program specified on pages 7 through 10.

RULE I. INITIAL ELIGIBILITY

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

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

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

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

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

RULE II. CONTINUATION OF ELIGIBILITY

Bargaining Unit Employees

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

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

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

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

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

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

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

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

Non-Bargaining Unit Employees and Alumni

If you are a non-bargaining unit employee or alumni, you will continue to be eligible for each month employer contributions are credited as follows:

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

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

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

A non-bargaining unit employee or alumni will continue to be eligible for each month for which he is credited with 30 hours for each week of the month while he is receiving credit under Rule IV on page 17.

RULE III. SELF-PAYMENT OPTIONS

If employer contributions have not been received for you for the required number of hours of work to maintain eligibility, you may make self-payments to maintain your and your dependents' eligibility under either Self-Payment Option 1 or Self-Payment Option 2.

Self-Payment Option 1 is the Fund's traditional self-payment provision and Self-Payment Option 2 is the COBRA continuation coverage provision required by law. If you elect to continue coverage under Self-Payment Option 1 and you subsequently become ineligible for that Option (i.e., you are no longer available for full-time work in the Fund's jurisdiction), you can continue to make self-payments for the remaining months for which you are eligible under COBRA. If you elect Self-Payment Option 2, any continuation rights that may be available under Self-Payment Option 1 are waived.

Self-Payment Option 1

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

When you make a self-payment under Self-Payment Option 1, the number of hours on which the self-payment is based will be credited as work hours solely for the purpose of determining future eligibility. This provision will not apply to employees who are partially unemployed and making self-payments to continue coverage under the Reduced Plan Option.

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

When Employed Less Than 390 Hours Per Quarter

You will be allowed to make self-payments to the Fund to continue full Class C coverage, provided you are available for full-time covered employment. The self-payment amount is equal to the lesser of the difference between hours credited to you by employer contributions or self-payments for a Contribution Quarter and 390 hours or the difference between hours credited to you for the previous 12 months and 1,560 hours, multiplied by the prevailing contribution rate.

When Completely or Partially Unemployed in Fund's Jurisdiction

The following two options are available provided you certify in writing that you are available for covered employment in the Fund's jurisdiction, you are completely unemployed or credited with 120 hours or less of covered employment in the Work Quarter preceding the Coverage Quarter, and you are credited with 1,290 hours or less in the four Work Quarters preceding the Coverage Quarter:

1. All Class C benefits as described in the Schedule of Benefits; or

2. Class C Health Care Benefits only but at increased deductible, copayment, and out-of-pocket maximum amounts as described on page xiii, Reduced Plan Option.

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

If, while completely or partially unemployed in the Fund's jurisdiction, you select the Reduced Plan Option, you may continue coverage under such option provided you work 120 hours or less at covered employment during a Work Quarter.

If you work 121 or more hours of covered employment in a Work Quarter, the Reduced Plan Option no longer is available. When the Reduced Plan Option no longer is available and you choose to continue coverage, you may continue full Class C benefits according to the prior subsection.

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

Special Temporary Rules: If you lose eligibility on or after the Coverage Quarter beginning May 1, 2009, Trustees have established a temporary subsidized self-payment rate for the Reduced Plan Option.

To qualify for the subsidized self-payment rate, you: must certify in writing that you are available for full-time covered employment in the Fund's jurisdiction; and must experience a loss of eligibility due to a reduction in work hours or termination of covered employment that results in your inability to maintain eligibility with employer contributions.

When you are credited with employer contributions in a Work Quarter that result in a self-payment amount that is less than the current rate for the corresponding Coverage Quarter, your coverage will be returned to full Class C benefits at the applicable self-payment amount.

These temporary provisions will remain in force until terminated by Trustees.

When Injured or Sick

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

1. such injury or sickness prevents you from actively working at covered employment;

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

3. the injury or sickness has not resulted in your total and permanent disability.

Trustees may require a statement from your physician as evidence that you are temporarily unable to work at covered employment due to the injury or sickness.

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

When an Employee Dies

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

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

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

After your accumulated eligibility has been exhausted, your eligible surviving spouse will be permitted to continue coverage under the applicable retiree class of coverage for herself and your eligible dependents (as defined on pages 76 and 77) by making self-payments.

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

1. your surviving spouse remarries;

2. your surviving spouse and/or dependent children become eligible for benefit coverage from another group health care plan by reason of employment (whether or not they actually do participate in such plan); or

3. your surviving spouse and/or dependent children establish residence outside of the United States.

When an Employee Retires or is Totally and Permanently Disabled

Please Note: Retiree benefits are subject to change or discontinuation as determined by Trustees. Trustees retain the right in their sole discretion to modify or discontinue retiree eligibility rules, types and amount of benefits, terms and conditions under which benefits are payable, and self-payment rates.

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

Exception: If a retired employee works and is credited with 390 or more hours during any Work Quarter, and such retired employee and/or retired employee's spouse is Medicare-eligible, the Medicare-eligible person(s) will receive Class C active employee benefits for the corresponding Coverage Quarter. If in any subsequent Work Quarter such retired employee is credited with less than 390 hours, benefits for the Medicare-eligible person(s) for the corresponding Coverage Quarter will revert back to the Class under which the retired employee was covered just prior to reinstatement in Class C.

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

If you or your dependent opt to enroll in Medicare Prescription Drug Benefits, your Medicare Prescription Drug Plan will become the primary payer for your prescription drug benefits, unless you are covered under an Active Plan through North Central States Regional Council of Carpenters' Health Fund, in which case the Fund remains the primary payer. The Fund will consider your prescription drug expenses for payment only after the expenses have been considered by your Medicare Prescription Drug Plan. In addition, it will be your responsibility to submit proof of what the Medicare Prescription Drug Plan paid (Explanation of Benefits) before the Fund considers any balance. ***If you or your dependent opt to enroll in Medicare Prescription Drug Benefits and drop coverage under the Plan, such person will lose all Plan benefits (including death, health care, optional dental and vision, and prescription drug). You will not be eligible to reinstate in the Retiree Program at a later date.***

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

1. **Retiree Program Requirements**

To be considered retired and eligible under this section, "When an Employee Retires," you must:

a. provide written proof of retirement from your pension fund or be receiving Social Security retirement benefits; and

b. be eligible as an active employee during the Coverage Quarter immediately preceding the effective date of coverage in the Retiree Program [however, this requirement will be waived for employees who: became permanently partially disabled, as determined by Trustees, on or after January 1, 2001; retired on or after January 1, 2005; have been credited with 35,000 or more hours of contributions from contributing employer(s) at the time of retirement; and are unable to perform enough covered work due to such disability in order to be eligible in the Coverage Quarter immediately preceding retirement]; and

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

d. make the self-payment at a rate to be determined by Trustees from time to time no later than the 25th day of the month preceding the current coverage month.

In the event an employee is unable to satisfy the requirements set forth in the prior subparagraph 1.a. because he is a Non-Bargaining Unit or Alumni Employee, the following will be considered proof of retirement:

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

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

c. If an office employee who is not an owner or officer, a letter from the company verifying your retirement.

You may be unable to satisfy the requirements in the prior subparagraph 1.c. because the collective bargaining unit in which you are employed has not participated in the Fund for five years. In that case, eligibility for participation may be determined by Trustees in other ways than from Fund records, such as determining your relationship to the industry prior to the bargaining unit joining the Fund.

2. **Retiree Program Reinstatement**

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

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

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

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

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

Subsidy rates will not increase after retirement because of your age or return to covered employment.

Surviving spouses are eligible for the retiree plan and the scheduled subsidy to the extent their deceased spouse satisfied the eligibility requirements. If you die either before or after retirement, your surviving spouse retains the rights to your subsidized rate, so long as Trustees continue the practice.

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

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

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

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

The following persons will be eligible to make **nonsubsidized** self-payments under the Retiree Program at a rate to be determined by Trustees from time to time:

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

b. Retirees who do not maintain membership in a participating union or do not maintain continuous payment of a service fee to the Health Fund.

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

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

If you work for a nonsignatory employer in the construction industry, all eligibility for benefit coverage for you and your dependents will terminate effective the first day of the calendar month following notice to you from the Fund Administrative Manager (but not earlier than 20 days after the date of such notice). You will not be permitted to make self-payments under Self-Payment Option 1 as of such termination date. However, you will be permitted to make self-payments under COBRA Self-Payment Option 2. These provisions do not apply to any claim incurred before you lose eligibility for benefit coverage under this paragraph.

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

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

Self-Payment Option 2 (COBRA)

The intent of these Eligibility Rules is to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended in all respects, including those changes required by subsequent legislation including, but not limited to, the Omnibus Budget Reconciliation Acts of 1989, 1990, and 1993, the Health Insurance Portability and Accountability Act of 1996, and the American Recovery and Reinvestment Act of 2009 (ARRA) and subsequent legislation. Any future IRS guidelines will be incorporated even if it conflicts with existing Plan provisions.

You or your dependents who do not qualify for or do not use Self-Payment Option 1 may, as Qualified Beneficiaries, continue eligibility for: Health Care Benefits only; or Health Care, Vision Care, and Dental Care Benefits, subject to the following conditions.

Qualifying Events

Certain events which cause you or your dependent to lose eligibility under the Plan are Qualifying Events.

Qualifying Events occur for you as an employee eligible because of employer contributions upon:

1. a reduction in hours of covered employment for any reason, including, but not limited to, disability, sickness, retirement, strike, lockout, or layoff; or

2. voluntary or involuntary termination of covered employment for any reason (except gross misconduct on your part), including disability, sickness, or retirement.

Qualifying Events occur for spouses and dependent children upon any of the following events occurring while you as an employee are eligible because of employer contributions:

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

2. your death;

3. divorce or legal separation from you;

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

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

The start of bankruptcy action of an employer contributing in behalf of Class O non-bargaining unit employees is a Qualifying Event for such employees if the bankruptcy results in loss of coverage. Further, continuation coverage is available to Qualified Beneficiaries whose coverage is substantially eliminated within one year before or after the bankruptcy proceeding commenced.

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

Notifications and Due Dates

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

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

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

2. **Trustees' Responsibility to Notify a Qualified Beneficiary When the Qualifying Event is Loss of Coverage Due to the Employee's Death, Divorce or Legal Separation, or to a Dependent Child Ceasing to Meet the Definition of Dependent**

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

3. **Trustees' Responsibility to Notify a Qualified Beneficiary When Other Qualifying Events Occur**

The Fund Office, not later than 30 days after receipt of notice of your loss of coverage from your employer or by examining monthly contribution reports, will advise the Qualified Beneficiary of the coverages, options, costs, and duration of these COBRA payment privileges.

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

A Qualified Beneficiary has 60 days from the date of coverage termination or the receipt of the COBRA Continuation Coverage Notice of Termination and Election Form, whichever is later, to elect whether to continue coverage. The election should be communicated to the Fund Office in writing on an Election Form. Each employee, spouse, and dependent child has the right to make his own individual election. However, covered employees may elect to continue coverage in behalf of their spouses, and parents may elect to continue coverage in behalf of their dependent children. Failure to state the election to the Fund Office within 60 days terminates rights to continued coverage under this provision.

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

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

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

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

Coverages and Options

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

1. Health Care Benefits only; or

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

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

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

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

Cost of Continuation Coverage

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

Duration of Continuation Coverage

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

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

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

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

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

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

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

Multiple Qualifying Events

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

Termination of COBRA Payment Provisions for Qualified Beneficiaries

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

1. The Plan no longer provides group health care coverage to any eligible employee.

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

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

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

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

6. A Qualified Beneficiary first becomes covered, after electing COBRA continuation coverage, under another group health care plan that does not impose any exclusions or limitations for pre-existing conditions of the Qualified Beneficiary.

7. The maximum continuation coverage period is reached.

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

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

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

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

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

If you are:

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

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

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

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

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

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

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

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

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

RULE VI. REINSTATEMENT OF ELIGIBILITY

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

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

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

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

RULE VII. EMPLOYMENT OUTSIDE OF THIS FUND'S JURISDICTION

A participating employer may continue to contribute in behalf of employees working outside the territorial jurisdiction of any union that is party to the Trust Agreement, provided they have a special agreement to fund out-of-area hours to Home Fund. However, the employer must continue to be recognized as a signatory employer by Trustees.

RULE VIII. EFFECTIVE DATE OF COVERAGE

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

RULE IX. TERMINATION OF COVERAGE

Employees

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

1. the date the Plan terminates;

2. the date you no longer are eligible according to the Eligibility Rules adopted by Trustees;

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

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

For Classes C and O, the eligibility for benefits of the employer's non-bargaining unit employees and their dependents will be terminated, and no benefit claims will be paid in their behalf, in the event the employer becomes delinquent in the payment of Fund contributions for the employer's bargaining unit employees under the applicable collective bargaining agreement.

Dependents

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

1. the date the Plan terminates;

2. the date you no longer are eligible according to the Eligibility Rules adopted by Trustees;

3. the end of the month your dependent no longer meets the requirements for the Plan's definition of "Dependent;"

4. the date the dependent enters the uniformed services on full-time active duty;

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

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

Certificate of Creditable Coverage: In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will issue a certificate of creditable coverage, free of charge, to you and your dependents when your regular health care benefits coverage terminates, you and your dependents become entitled to elect COBRA continuation coverage, or COBRA continuation coverage terminates (and also upon request, before you or your dependents lose coverage or within 24 months of losing coverage). The certificate provides information on your period of coverage under this Plan that may be credited in your behalf to satisfy any applicable pre-existing condition limitations of a new health plan in which you enroll.

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

References to accumulated eligibility do not apply to Class O.

1. Eligibility Status

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

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

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

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

e. Your eligibility will be reinstated on the date you return to work for a participating employer (or upon making yourself available for work if no such work is available) within the applicable time limits stated in subsection 3., provided you otherwise satisfy the reemployment requirements necessary to qualify for reemployment rights under USERRA (e.g., provide evidence of honorable discharge, cumulative service in the uniformed services of no longer than five years). If your accumulated eligibility has been exhausted, you will be allowed to make self-payments under Self-Payment Option 1 to be immediately reinstated in the Plan until you earn sufficient accumulated eligibility to sustain Plan coverage.

2. Continuation of Coverage

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

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

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

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

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

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

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

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

: 24 months from the first date of absence due to service in the uniformed services; or

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

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

3. Status Upon Return from Military Service

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

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

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

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

Such time periods may be extended up to two years for injuries or sicknesses, as determined by the Secretary of Veteran Affairs, to have been incurred or aggravated during your service in the uniformed services. If you exhaust your accumulated eligibility prior to your return from uniformed service and you do not have USERRA reemployment rights, you will be treated as a new employee.

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

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

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

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

RULE XI. COVERAGE WHILE ON FAMILY AND MEDICAL LEAVE

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

To be subject to the Act, an employer must have at least 50 employees within 75 miles of that worksite.

If your leave is eligible under the FMLA, and you do not return to work after the leave, then for COBRA continuation coverage purposes under Rule III on pages 4 through 17, the date of the Qualifying Event will be the last day of your FMLA leave. This provision will apply whether or not you elect to continue coverage under the Plan during the leave.

For additional information regarding your rights under the Family and Medical Leave Act, see page 99.

RULE XII. ELIGIBILITY FOR EMPLOYEES WHOSE CONTRIBUTIONS ARE PARTLY MADE TO THE NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND AND PARTLY TO SOME OTHER FUND (RECIPROCITY)

Contributions paid by an employer to another health care plan in your behalf may be transferred to this Plan provided:

1. this is your home fund;

2. you authorize the transfer; and

3. there is a reciprocity agreement in effect between this Plan and the other plan.

Where an out-of-town health fund has reciprocity arrangements with this Fund, the employer contributions paid to such other fund will be credited under the arrangements set forth in the reciprocity agreement upon receipt of the contributions and related employment information by this Fund.

When the contribution amount required to be paid to such other fund is different than the amount required to be paid to this Fund, the monies received will be prorated and the resultant hours will be credited to your record.

RULE XIII. CHANGE OF ELIGIBILITY RULES

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

RULE XIV. CONTRIBUTIONS FROM SELF-EMPLOYED

Contributions from self-employed persons will not be accepted.

RULE XV. CONFORMITY WITH INTERNAL REVENUE CODE

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

RULE XVI. SPECIAL ENROLLMENT PERIODS

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

   A special enrollment period is allowed for you, or your dependent, who waived coverage under the Plan in writing if either:

   a. you or your dependent is covered under a Medicaid plan or state Children's Health Insurance Program (CHIP), coverage of you or your dependent is terminated as a result of loss of eligibility, and you request coverage under the group health plan no later than 60 days after the date coverage terminates; or

   b. you or your dependent becomes eligible for assistance under a Medicaid plan or state CHIP (including under any waiver or demonstration project conducted under or in relation to those plans), and you request coverage under the group health plan no later than 60 days after the date you or your dependent is determined to be eligible for assistance.

Special enrollment under this provision must be requested within 60 days of the date of the events described in a. or b. of the preceding paragraph of this provision.

2. Special Enrollment Period for Other Coverage

A special enrollment period is allowed for you, or your dependent, who waived coverage under the Plan in writing if you or your dependent:

a. had other coverage and either later had a loss of eligibility for such coverage or employer contributions toward such coverage were terminated; or

b. were on continuation coverage under COBRA under another plan, but eligibility for COBRA expired; or

c. had other coverage and reached the lifetime maximum for all benefits.

Special enrollment under this provision must be requested within 30 days of the date of the events described in a., b., or c. of the preceding paragraph of this provision.

NOTE: Your or your dependent's action or inaction regarding the release or exchange of information between this Plan and any insurance company, other organization, or person when such information is necessary to determine eligibility and pay benefits may cause your eligibility to be suspended. Benefits will not be paid when you withhold consent for release or exchange of information.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

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

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

DEDUCTIBLE

The deductible is the amount of covered charges which you pay before you are entitled to begin receiving benefit payments. The deductible is stated in the Schedule of Benefits. The deductible amount will be waived for the alternative ways of obtaining care on pages 39 through 41 and preventive care on pages 37 and 38. The deductible applies only once in any calendar year even though you may have several different disabilities. So that you will not have to satisfy a deductible late in one calendar year and soon again the following year, any expenses applied against the deductible in the last three months of a calendar year also may be applied against the deductible in the next calendar year.

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

COPAYMENT

After satisfaction of the deductible amount, the Plan pays a percentage of reasonable expenses incurred for covered charges at the applicable copayment stated in the Schedule of Benefits, depending upon use of a preferred provider and/or satisfaction of precertification requirements. The remaining copayment and any charges in excess of the reasonable amount are payable by you. **In the case of a provider participating in the Preferred Provider Network, you are not responsible for any amounts which exceed the provider's negotiated charge.**

When an eligible person's out-of-pocket expenses for covered charges incurred for a calendar year have reached the out-of-pocket maximum stated in the Schedule of Benefits, the Plan will pay 100% of covered charges for such person(s) for the remainder of that calendar year, up to the calendar year maximum, unless otherwise specified.

The copayment amount will be waived for the alternative ways of obtaining care on pages 39 through 41 and preventive care on pages 37 and 38.

CALENDAR YEAR MAXIMUM

Benefits payable under Comprehensive Major Medical Benefits will be limited to the maximum per eligible person per calendar year for essential health benefits stated in the Schedule of Benefits.

Non-essential health benefits are not included in the calendar year maximum for essential health benefits. Non-essential health benefits include: voluntary sterilizations (see page 29); acupuncture by a licensed acupuncturist subject to specified medical guidelines (see page 29); non-surgical treatment of TMJ (see page 30); physicians' services, lab work, and patient education in a medical setting for the treatment of morbid obesity (see page 30); infertility testing (see page 31); non-prescription drugs and medicines, provided a physician has recommended and made a written order for their use (see page 31); vision therapy (see page 31); wigs and toupees when hair loss is the result of a disease or medical treatment (see page 32); hearing aids (see page 32); experimental medical treatment and procedures (see page 33); genetic testing (see page 33); hospital admission kits when billed separately by the hospital (see page 33); and artificial life support (see page 62). Vision Care Benefits, Dental Care Benefits, Death and Accidental Death and Dismemberment Benefits, and Accident and Sickness Weekly Benefits also are considered non-essential benefits and are payable as stated in the Plan.

COVERED CHARGES

Benefits are payable for reasonable expenses for the following services and supplies which are medically necessary for treatment of an injury or sickness.

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

1. semi-private room and board expense and confinement in an intensive care unit;

2. drugs, medicines, diagnostic x-rays and laboratory tests, and other hospital miscellaneous services and supplies not included in room charges, if used while confined in the hospital as a resident patient;

3. outpatient services in connection with surgery or related charges; and

4. emergency room services and supplies for the treatment of injury or sickness. There is a separate $50 copayment for each hospital emergency room visit in addition to being subject to the Plan's deductible and copayment provisions. This copayment is waived when admitted to the hospital as inpatient or for observation. This copayment will not apply towards satisfaction of your deductible or out-of-pocket maximum. All emergency services in an emergency department of a hospital are payable at the in-network level of benefits even if services are obtained at an out-of-network provider.

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

[1] See page 49 for the benefits payable at a preferred provider hospital. See the Schedule of Benefits for the copayment reduction and out-of-pocket penalty assessment for hospitalizations which have not been precertified as specified on page iv.

Hospital charges for room and board and miscellaneous charges for a healthy newborn dependent child are payable the same as any other disability during the period the mother of the child is hospital-confined as the result of giving birth to the child. In no event will hospital benefits exceed five days or continue after the child's mother no longer is hospital-confined as a result of giving birth to the child. Benefits are payable for state-required laboratory tests for newborn dependents. Such benefits are payable up to the amount charged by the State Lab of Hygiene.

The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a hospital length of stay not in excess of these periods. However, 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 or 96 hours, as applicable.

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

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

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

1. Surgery[1] by a physician or surgeon (and active services as an assistant surgeon), including the repair of a dislocation or fracture, up to the reasonable expense fee allowance.

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

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

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

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

Benefits are payable for one voluntary sterilization per lifetime for the employee and dependent spouse only.

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

For individuals receiving mastectomy-related benefits, coverage will be provided on the same basis as other medical and surgical procedures covered by the Plan and in a manner determined in consultation with the attending physician and the patient for all stages of reconstruction of the breast and nipple of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses and surgical bras; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits are payable in addition to those payable for the mastectomy itself and related hospital costs. Benefits will be payable for the reconstructive surgery, whether performed immediately after a mastectomy or delayed to a later date, provided the person was eligible under the Plan at the time the mastectomy was performed.

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

2. Anesthetic and its administration by a professional anesthetist. The services of a physician and certified registered nurse anesthetist jointly providing anesthesia service will be paid at 50% of the Plan's reasonable expense fee allowance for each provider, or if a preferred provider, at 50% of the total allowance under the PPO fee schedule.

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

Services of a chiropractor are limited to treatment of musculoskeletal conditions. The maximum payment per outpatient chiropractic visit is stated in the Schedule of Benefits. Coverage is provided for chiropractic care for dependent children ages 6 to 12 for treatment of documented injuries only, unless medical necessity is established by a physician. There is no coverage under the Plan for chiropractic care for infants and dependent children ages 5 and under, unless medical necessity is established by a physician.

Coverage for acupuncture by a licensed acupuncturist, subject to medical guidelines which specify certain conditions and diagnoses for which acupuncture is recognized to be effective, including but not limited to: postoperative or chemotherapy-related nausea or vomiting; nausea associated with pregnancy; fetal breech position; temporomandibular joint disorders (TMJ); and chronic pain for certain conditions such as migraine headaches, osteoarthritis of the knee or hip, and chronic low back pain. The maximum per person each calendar year for acupuncture services is stated in the Schedule of Benefits.

The services of a licensed psychiatrist (M.D.) are payable for the outpatient treatment of nervous and mental disorders, substance abuse, and alcoholism. Expenses related to services of a psychologist, therapist, or counselor for these three conditions are covered to the same extent as those of a physician.

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

4. Services of a physician related to your or your spouse's routine physical (see page 37 for details).

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

6. Services of physician related to routine well child care (see page 37 for details).

7. Diagnostic tests, therapy, and treatment (exclusive of surgery which is covered the same as any other surgical procedure) related to temporomandibular joint disease (TMJ), up to the maximum per person per calendar year stated in the Schedule of Benefits. Payment will be made whether the work is performed by a physician (M.D.) or Doctor of Dental Surgery (D.D.S.).

8. Physicians' services, lab work, and patient education in a medical setting for the treatment of morbid obesity, up to the lifetime maximum per person stated in the Schedule of Benefits, subject to criteria maintained at the Fund Office.

9. Sclero-therapy for medically necessary treatment of varicose veins.

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

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

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

Benefits also are payable for infertility testing for employees and dependent spouses, up to the lifetime maximum for such services stated in the Schedule of Benefits. Coverage will not be provided for treatment of infertility, including prescription drugs, artificial insemination, gamete intra-fallopian transfer (GIFT), intrauterine and invitro-fertilization, perganol, and surgical intervention for the sole purpose of treating infertility.

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

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

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

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

3. Non-prescription drugs and medicines, provided a physician has recommended and made a written order for their use. Benefits paid for non-prescription drugs are limited to the maximum per person per calendar year stated in the Schedule of Benefits.

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

See the description of the Preferred Provider Pharmacy Program on pages 46 through 48 for benefits payable for all other prescription drugs.

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

1. Other hospital charges incurred as an outpatient.

2. Charges of--

    : a qualified physical or occupational therapist, which are medically necessary to restore a function lost due to injury or sickness. Preauthorization is recommended after the initial evaluation and eight sessions (see page xviii).

    : an appropriately trained professional for speech therapy or feeding therapy to restore a function lost due to injury or sickness.

    : an appropriately trained professional, such as an optometrist, for vision therapy, up to the separate lifetime maximum for such therapy stated in the Schedule of Benefits.

: a registered nurse for nursing service rendered solely for the eligible person, except for services provided by a person who ordinarily resides in the eligible person's household or is a member of the family.

: a nurse practitioner acting within the scope of such license.

: a nurse midwife for a normal delivery at a hospital, payable at the same benefit level as when such services are performed by a physician.

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

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

: radiation therapy.

: blood or blood plasma and its administration.

: testing of pacemakers.

: casts.

: initial artificial limbs and eyes to replace natural limbs and eyes within six months of the date of the loss.

: medically necessary replacement of artificial limbs and eyes.

: initial contact or implanted lens if used to replace a lens removed because of a cataract.

: initial breast prosthesis for breast removed due to mastectomy within six months of the mastectomy and one replacement prosthesis for each breast every three calendar years.

: costs related to the medically necessary removal and replacement of faulty breast implants that were initially implanted following a mastectomy.

: wigs and toupees when hair loss is the result of a disease or medical treatment, up to the lifetime maximum stated in the Schedule of Benefits.

: dental services rendered by a physician or dentist for treatment within 12 months of an injury to the jaw or natural teeth, including the initial replacement of these teeth and any necessary dental x-rays.

: one hearing aid exam per person once every three calendar years and one hearing aid per ear once every three calendar years when prescribed by a physician, up to the maximum per aid stated in the Schedule of Benefits.

: initial newborn dependent child hearing exam when performed on an outpatient basis, provided such test would have been covered if mother and child had remained hospital-confined.

5. Experimental medical treatment and procedures, as defined on page 78, up to the aggregate maximum per disability stated in the Schedule of Benefits. Preauthorization is recommended (see page xviii).

6. Specified medical supplies and durable medical equipment as determined by Trustees from time to time and of which a written record is maintained by CMS. It is recommended that you obtain preauthorization for certain supplies and equipment (see page xviii). CPAP, BiPAP, and AutoPAP replacement supplies are covered up to the maximum per person per calendar year stated in the Schedule of Benefits. The Plan will cover: repair of covered durable medical equipment when the damage is not due to abuse or neglect, the cost of repair is projected to be less than the cost of replacement, the equipment has been maintained according to the manufacturer's recommended maintenance schedule, and CMS has authorized the repair in advance; and medically necessary replacement of covered durable medical equipment.

7. Medically necessary genetic testing, up to the lifetime maximum stated in the Schedule of Benefits. Preauthorization is recommended (see page xviii).

8. Hospital admission kits when billed separately by the hospital, up to the maximum per admission stated in the Schedule of Benefits.

9. Amniocentesis (for employee and dependent spouse only) when there is a documented medical indication of a potential injury or sickness of the fetus or mother. Preauthorization is recommended if under the age of 35 (see page xviii).

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

Organ Transplants. Benefits are payable for covered charges incurred during the transplant benefit period for a human organ or tissue transplant to a recipient who is an eligible person, up to the amounts stated in the Schedule of Benefits.

The transplant benefit period consists of five days before and eighteen months after the date of the transplant for those procedures that are self-funded. For procedures that are insured, the transplant benefit period is a period from the date of evaluation to 365 days post-transplant.

Benefits for organ transplants are payable provided each of the following conditions is satisfied:

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

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

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

4. The eligible person must contact the Fund Office to initiate the organ transplant approval process. For transplants that are self-funded: The Board of Trustees approves the transplant decision, based on the specialists' certification and may designate approved transplant facilities.

Transplants of the following human organs or tissues when transplanted to an eligible person are covered under an insurance policy issued by a carrier Trustees select (except that for Medicare-eligible persons in Classes S, T, U, and V, Medicare-approved transplants are provided directly through the self-funded Plan of benefits):

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

Coverage for cornea transplants is provided directly through your self-funded Plan of benefits (as defined on page 83) for all classes.

Covered charges include reasonable expenses incurred for the following services and supplies, provided the transplant recipient is an eligible person:

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

2. For insured transplants only: Transportation, lodging, and meals for the recipient and an immediate family member or significant other person to and from the transplant site. Benefits also are payable for lodging and meal costs incurred by

the companion during the recipient's hospital stay. For benefits to be payable, itemized receipts for these charges are required.

Daily lodging and meal costs are payable up to the maximum stated in the Schedule of Benefits. The aggregate maximum for all transportation, lodging, and meals during an entire transplant benefit period also is stated in the Schedule of Benefits.

3. For insured transplants only: Private nursing care for the recipient by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), up to the maximum stated in the Schedule of Benefits.

4. Postoperative followup expenses, including immunosuppressant drug therapy. For insured procedures, immunosuppressant drugs are covered under the insurance policy only during the transplant benefit period. After the transplant benefit period, the Plan covers expenses for such drugs, subject to applicable requirements.

5. For insured transplants only: Coverage is provided for the use of mechanical circulatory assist devices (MCADs) at the time of insertion and continuing for ten days. The MCAD must be FDA-approved and the eligible person must be listed as an acceptable candidate on the United Network for Organ Sharing (UNOS) transplant waiting list in an approved facility within seven days of the device insertion.

6. All covered services for the recipient will be payable under the Plan the same as for any other injury or sickness (or under the insurance policy up to its lifetime maximum).

7. For procedures covered under the insurance policy, you have the option of either using any facility for the transplant or of using a facility that is part of the carrier's transplant network for inpatient care. If you opt not to use a network facility, benefits are reduced as stated in the Schedule of Benefits.

8. If an eligible person requires more than one covered transplant procedure, covered transplant services during each transplant benefit period are payable as follows. If each covered transplant procedure is due to unrelated causes, each covered transplant procedure will begin a separate transplant benefit period. If each covered transplant procedure is due to related causes, each covered transplant procedure will begin a separate transplant benefit period if, in the case of an eligible employee, the transplant procedures are separated by the eligible employee’s return to being actively employed for 90 days, and in the case of a dependent, the transplants are separated by at least 90 days. If the covered transplant procedures are due to related causes, they are considered one transplant benefit period when not separated as stated and the covered transplant benefit period is determined in accordance with the earlier covered transplant procedure. All insured transplant procedures are subject to the insurance policy’s lifetime maximum per eligible person regardless of the

number of covered transplant procedures performed. Reasonable expenses for insured organ transplants in excess of such lifetime maximum are payable under Comprehensive Major Medical Benefits provisions.

For self-funded transplants, benefits for replacement transplant(s) if the first organ fails are limited to 50% of the maximum amount otherwise payable. For insured transplants, benefits for replacement transplant(s) if the first organ fails or is rejected are payable the same as for the initial transplant, unless such failure or rejection is due to physician or hospital error in which case no benefits are payable.

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

10. If an eligible transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits are payable for the following for insured transplants: covered organ transplant services up to the earlier of the intended recipient's death; or the date the decision is made by the intended recipient's physician not to perform the covered transplant procedure.

No organ transplant benefits are payable for:

1. services not ordered by a physician;

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

3. animal or mechanical organs for transplantation;

4. investigational drugs;

5. any items specified in the Plan's General Exclusions on pages 60 through 65 of this SPD;

6. purchase of the organ or tissue;

7. the temporary use of experimental mechanical equipment; or

8. for insured transplants, experimental treatment as defined by the insurance policy.

PREVENTIVE CARE

When Obtained at a Network Provider

The Plan will pay 100% of reasonable expenses with no deductible requirement and no calendar year maximum for the following preventive services obtained at a network provider. Covered charges include:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, including but not limited to: routine pap smears; routine hearing exams; routine physical exams for employee and dependent spouse, including office visit and routine x-rays and laboratory tests; and colorectal cancer screening, including routine colonoscopy and flexible sigmoidoscopy but specifically excluding CT colonography (virtual colonoscopy).

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention with respect to the individual involved. The Plan does not cover immunizations recommended or required for foreign travel. If you have a question about whether a specific immunization is covered, please call the Fund Office.

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

4. With respect to preventive services for women, as required by the Affordable Care Act, evidence-informed preventive care and screening as follows:

   : Annual well-women preventive care visits unless more than one is needed to obtain all necessary services. This includes visits to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.

   : Gestational diabetes screening for pregnant women between 24 and 28 weeks gestation and who are identified at high risk for diabetes at first prenatal visit.

   : Human papillomavirus (HPV) DNA screening for women age 30 or older, once every three years.

   : Annual counseling on HIV and sexually transmitted infections (STIs) for sexually active women.

   : Contraception counseling, injectable hormones, implanted devices, and sterilization for women with reproductive capacity. See page 47 for contraceptive methods covered under the PPRx.

: Lactation support and counseling for pregnant and postpartum women, and breastfeeding equipment. Electric or manual breast pumps are limited to one every five calendar years.

: Annual screening and counseling for interpersonal and domestic violence.

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

http://www.healthcare.gov/law/about/provisions/services/lists.html

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

When Obtained at an Out-of-Network Provider

When any preventive services are obtained at an out-of-network provider (or if they are obtained at an in-network provider but are not on the previously specified list), the Plan will pay:

1. 100% of reasonable expenses up to the routine physical examination or well child care maximum, as applicable, stated in the Schedule of Benefits. Supplemental routine care charges are payable at 20%. Your copayment is not applied to the annual out-of-pocket maximum.

2. 90% of reasonable expenses with no deductible or calendar year maximum for routine colonoscopy and electrocardiograms (EKG).

3. 100% of reasonable expenses for the following routine immunizations. For adults, this includes immunizations for tetanus, Hepatitis B, influenza, pneumonia, and shingles. For dependent children, it includes immunizations required to attend public schools as well as annual influenza shots.

In lieu of benefits provided under this section, you or your dependent spouse may prefer to take advantage of the Preferred Provider Preventive Care Program. See page 50 for details of the Program.

Limitations. Benefits will not be paid for examinations for which benefits are provided under any other section of the Plan.

ALTERNATIVE WAYS OF OBTAINING CARE

Deductibles and copayments are waived for the following benefits available under Comprehensive Major Medical Benefits to encourage you and your physician to consider their use. If you and your physician use these less costly systems and facilities for treatment, you will help keep your own and Plan costs under control. These benefits are subject to all other provisions of the Plan.

Hospice Care

Hospice care allows a terminally ill patient to receive appropriate care in the most comfortable, home-like atmosphere possible. When it is medically determined that an eligible person is terminally ill, the eligible person (or authorized representative, such as a family member) and the physician may prefer to obtain hospice care as opposed to hospital confinement. Benefits are payable for the full reasonable amount of covered hospice services during the period in which the eligible person otherwise would have to be hospital-confined, subject to rates established by Trustees from time to time. Benefits are payable for home care administered under an approved hospice program or home health care agency at the patient's home, or for care in a hospice unit of a hospital or a separate hospice facility.

The following hospice care services are covered:

1. physicians' visits;

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

3. assessment visit by a hospice program staff member;

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

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

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

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

Home Health Care

Reasonable expenses for home health care services provided in the patient's home are covered by the Plan provided the attending physician certifies that:

1. hospitalization or confinement in a skilled nursing facility would be required in the absence of home health care;

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

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

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

Home health care services include:

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

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

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

4. nutritional counseling by a registered dietician when medically necessary; and

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

Home health care benefits are NOT provided for:

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

2. custodial care;

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

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

5. any services not specifically listed in this section.

Skilled Nursing Facility Care

If you or your dependent are confined in a skilled nursing facility, benefits are payable for 100% of the reasonable expenses for up to 30 days of confinement per period of disability provided:

1. you are transferred to the skilled nursing facility within 30 days of hospital discharge;

2. you were hospital-confined based on medical necessity immediately before transfer to the skilled nursing facility;

3. skilled nursing facility care is needed for care of the same condition treated in the hospital;

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

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

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

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

Charges for skilled nursing facility care expenses must be precertified (see page xix).

EXCEPTIONS AND LIMITATIONS

In addition to the General Exclusions on pages 60 through 65 and other limits that apply to specific benefit provisions as described in those sections, Comprehensive Major Medical Benefits do not cover:

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

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

3. cosmetic surgery except for the repair or reconstruction of injuries within 12 months of the date of the injury;

4. treatment of mental or developmental deficiency or mental retardation; or

5. specified medical supplies and durable medical equipment for which you do not obtain preauthorization and such supplies and equipment are determined not to be medically necessary.

VISION CARE BENEFITS

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

You may obtain reduced prices on lenses, frames, and contact lenses purchased from a Preferred Provider Optical Center as described on page 49.

Vision Care Benefits are payable provided services are rendered or supplies are furnished by an optician, optometrist, or ophthalmologist.

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

1. vision examination;

2. prescription lenses and frames;

3. prescription sunglasses;

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

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

6. lasik eye surgery.

Exception: For dependent children under age 18, one vision exam every two calendar years will not be subject to the aggregate maximum.

Limitations

In addition to the General Exclusions on pages 60 through 65, Vision Care Benefits do not cover:

1. orthoptics, vision training, and aniseikonia;

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

3. expenses incurred for services performed or supplies furnished by other than an optician, optometrist, or ophthalmologist; or

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

DENTAL CARE BENEFITS

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

Dental Care Benefits cover expenses incurred during a calendar year for preventing dental disease, restoring teeth, replacing teeth, and oral surgery. After satisfaction of the deductible, the amount payable is limited to the copayment and maximum aggregate amount per calendar year stated in the Schedule of Benefits.

Exception: For dependent children under age 18, the following preventive dental services will be payable subject to the deductible and copayment, but will not be subject to the calendar year maximum: routine dental examinations, limited to two exams per person per calendar year, including bitewing x-rays once each calendar year; dental prophylaxis, limited to two per person per calendar year; topical fluoride applications, limited to two applications per person per calendar year; dental sealant applications; and full-mouth x-rays once every five years in lieu of bitewings.

Orthodontics is not subject to the deductible, copayment, or annual maximum, but has its own separate maximum per lifetime.

Dental Care Benefits are payable for reasonable expenses for the following, provided such services are rendered or supplies are furnished by a dentist or dental hygienist.

Preventive Care

Expenses incurred for preventive care performed by a dentist for all or any combination of the following:

1. prophylaxis, which may be performed by a dental hygienist under the direction and supervision of a dentist;

2. oral examination, including dental x-rays if professionally indicated;

3. diagnosis;

4. fluoride treatments;

5. space maintainers and related services; and

6. sealants.

Restorative Care

Basic dental care includes services performed by a dentist for an actual or suspected dental disease, defect, or injury. These benefits include, but are not limited to:

1. x-rays;

2. emergency treatment;

3. treatment of periodontal disease;

4. extraction;

5. root canal therapy;

6. crowns, fillings, and inlays (crowns are payable on seat date, not prep date); and

7. examinations and treatment in connection with an actual or suspected dental disease, defect, or injury.

Services related to injury are payable only after Comprehensive Major Medical Benefits have been exhausted for that injury.

Prosthetics

Prosthetic services performed by a dentist are covered for:

1. bridgework and repair of bridgework;

2. initial installation or repair of all prosthetics (payable on seat date, not prep date);

3. replacement of a partial denture;

4. replacement of an existing full upper or lower denture or full set of dentures; and

5. dental implants.

Oral Surgery

Expenses incurred for oral surgery are covered, excluding charges for procedures already covered under Comprehensive Major Medical Benefits.

Orthodontics

Expenses incurred while eligible under the Plan will be covered during an entire period of orthodontic treatment for initial and subsequent installation of orthodontic appliances. Benefits are payable for all orthodontic treatment and related services to facilitate orthodontic treatment, including extractions, rendered by a dentist before and after such installation. Orthodontic benefits are not subject to the deductible, copayment, or the Dental Care Benefits annual aggregate maximum but are subject to a separate orthodontic lifetime maximum stated in the Schedule of Benefits.

Limitations

In addition to the General Exclusions on pages 60 through 65, Dental Care Benefits do not cover any expense caused by, incurred for, or resulting from:

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

2. expenses incurred for services performed or supplies furnished by other than a dentist, except for prophylaxis which may be performed by a dental hygienist under the direction and supervision of a dentist; or

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

PREFERRED PROVIDERS

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

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

PREFERRED PROVIDER PHARMACY PROGRAM (PPRx)

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

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

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

Maintenance prescriptions are available for purchase up to a 90-day supply through the Express Scripts Mail-Service Preferred Provider Pharmacy. For each mail-service prescription filled through Express Scripts, you will pay the copayment for generic drugs or for brand name drugs per prescription as stated in the Schedule of Benefits.

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

There is no separate calendar year benefit maximum for prescriptions purchased through the PPRx. However, PPRx benefits are subject to the Comprehensive Major Medical Benefits calendar year maximum for essential health benefits.

If you use the PPRx while ineligible according to the Plan's Eligibility Rules, the Plan will recover the ineligible payments from you according to the right of recoupment provisions stated on page 59.

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

Covered Expenses

The following are covered expenses upon a physician's written prescription, unless otherwise specifically excluded:

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

2. Compounded medications of which at least one ingredient is a prescription legend drug.

3. Insulin.

4. Insulin syringes/needles by prescription.

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

6. Tretinoin (Retin-A) preparations, through age 25.

7. Prescription vitamin preparations, such as prenatal vitamins.

8. Prescription fluoride preparations.

9. Self-administered injectables and oral medications that are required to be purchased through the specialty pharmacy. A list of such medications is maintained at the Fund Office.

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

11. Contraceptives for women. Contraceptive methods covered under the PPRx include oral contraceptives, transdermal contraceptives (patch), vaginal hormonal rings, diaphragms, and emergency contraceptives (Plan B). The PPRx does not cover contraceptives available without a prescription, except Plan B emergency contraception for women age 17 and older. Generic and single-source brand name contraceptives are covered at a $0.00 copayment; multi-source brand name contraceptives are covered subject to the applicable brand name copayment.

12. Over-the-counter (OTC) aspirin for cardiovascular protection for men age 45-79 and women age 55-79.

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

14. Federal legend fluoride for dependent preschool children older than six months of age whose primary water source is deficient in fluoride.

15. OTC iron supplements for asymptomatic dependent children aged 6 to 12 months who are at increased risk for iron deficiency anemia.

16. OTC folic acid for doses of 400-800 mcg/day for women who are planning or capable of pregnancy.

17. Synagis when preauthorized by and purchased through the Specialty Pharmacy. When the initial dose is administered while a newborn is hospitalized, it will be payable under Comprehensive Major Medical Benefits, if preauthorized.

Limitations

The Preferred Provider Pharmacy Program does not cover:

1. implantable contraceptives, regardless of intended use;

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

3. alcohol deterrents;

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

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

6. experimental or investigational drugs;

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

8. weight loss medications;

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

10. drugs used to treat sexual dysfunction;

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

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

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

14. prescriptions which are not medically necessary for the diagnosis or treatment of an injury or sickness; or

15. drugs purchased at the hospital pharmacy at the time of discharge.

PREFERRED PROVIDER NETWORK

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

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

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

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

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

PREFERRED PROVIDER OPTICAL CENTER

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

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

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

Benefits are payable under the preferred provider agreement for the same type of eyewear and contact lens expenses as are covered under Vision Care Benefits on page 42 and are subject to the same limitations and maximum amounts stated in the Schedule of Benefits.

Eye examinations are not discounted under this preferred provider agreement.

PREFERRED PROVIDER PREVENTIVE CARE PROGRAM

For Employees and Dependent Spouses Only

You or your dependent spouse may choose to take advantage of the Preferred Provider Preventive Care Program offered through Health Dynamics. If you choose this option, the full cost will be paid by the Plan. However, the Plan will not pay for services more than once in any calendar year. For example, if you utilize the Health Dynamics Preventive Care Program and then you subsequently have one or more of the services included in the Health Dynamics exam performed in the same calendar year on a routine basis, they will not be covered a second time.

The Program includes a physician-directed examination which may be conducted by an M.D. or a physician's extender, such as a physician's assistant or nurse practitioner, and comprehensive preventive care testing. Women may have both a breast screen and pap test performed by Health Dynamics. **Please be aware that women who choose not to have a breast screen and/or pap test performed are not eligible for payment of such services with another provider in the same calendar year during which they use the Health Dynamics Program.**

After the testing, you will have a personal and confidential consultation session which will provide you not only with a medical evaluation but also a personal fitness report and recommendations that focus on your total well-being.

To schedule an appointment, call Health Dynamics at: (414) 443-0200 during office hours, Monday through Friday, 8 a.m. - 5 p.m. Contact the Fund Office for the current listing of locations to find the one nearest you. You also may visit their website at: www.hdhelpsu.com (username is: hdhelpsu and password is: hdhelpsu).

Once your appointment has been scheduled, a packet will be sent to you explaining fasting requirements, check-in procedures, and other pertinent information.

DEATH BENEFITS

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

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

Payment of Benefits.

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

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

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

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

Beneficiary. Death Benefits will be paid to your beneficiary of record.

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

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

Assignment of Benefits. Death Benefits are non-assignable.

ACCIDENT AND SICKNESS WEEKLY BENEFITS

Active Classes
Classes C and O
Employees Only

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

All Classes of Eligible Persons

COORDINATION OF BENEFITS WITH OTHER PLANS

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

An individual may have other health plan coverage containing a provision commonly known as a "wrap around" provision, "sub-plan" provision, or some similar provision whose purpose is to provide primary coverage only for a small amount of expenses, well below the maximum benefit available under the plan if no other coverage is available (collectively, a "sub-plan provision"). The effect or intent of a plan with a sub-plan provision is to transfer the much larger secondary coverage to the other health plan with which such plan is coordinating benefits. In the event this plan is coordinating benefits with a plan containing a sub-plan provision, the sub-plan provision will be treated as arbitrary and capricious and a subterfuge and will be ignored, resulting in coordination of benefits with the plan, sub-plan, or similar provision that would apply if the eligible person did not have coverage under this Plan.

Order of Benefit Calculation. If another plan or portion of a plan covering the eligible person does not contain a coordination of benefits provision, then that plan must determine the benefits it pays before this Plan does.

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

For the purposes of these rules, the term employee includes retired employee.

1. If a person is eligible as an employee in one plan and as a dependent in another, the plan covering the person as an employee is primary. If the person is a Medicare beneficiary and, as a result of federal law, Medicare is:

   a. secondary to the plan covering the person as a dependent;

   b. primary to the plan covering the person as an employee;

   then the order of benefits between the two plans is reversed so that the plan covering the person as an employee is the secondary plan and the other plan is the primary plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[1] Includes parents who last had primary physical placement of children as defined on pages 76 and 77.

The plan covering that same person as a retired or laid-off employee or dependent of such employee is the secondary plan.

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

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

Benefits of this Plan will be reduced to the extent necessary to prevent the other group plan from refusing to pay benefits available under its policy. Additionally, if a sub-plan exists, the sub-plan is not or cannot be ignored pursuant to the second paragraph on page 54; and the sub-plan is found by the Board of Trustees or a court of competent jurisdiction to apply, then this Plan expressly limits its secondary coverage available to the eligible person to the same dollar amount contained in, or calculated under, the sub-plan provision.

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

MEDICARE PROVISIONS

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

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

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

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

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

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

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

Neither you nor the Plan is responsible for paying any charges which exceed legal limits set by the Medicare Physician Payment Reform Act which limits the amount that physicians can bill Medicare patients above the Medicare allowance for a particular procedure or service unless services are privately contracted.

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

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

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

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

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

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

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

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

SUBROGATION/REIMBURSEMENT

Whenever the North Central States Regional Council of Carpenters' Health Fund has been or is providing hospital, medical, dental, vision, or disability benefits ("Benefits"), as a result of the occurrence of any injury, sickness, or death which results in a possible recovery of indemnity from any party, including an insurer, including uninsurance and underinsurance coverage, the Fund may make a claim or maintain an action against such party.

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

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

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

The eligible person or the Fund may make a claim against a party or commence an action against a party and join the other as provided under Section 803.3 of the Wisconsin Statutes or applicable state or federal law. Each will have an equal voice in the prosecution of such claim or action.

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

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

2. Any remainder will be paid to the eligible person on whose behalf claim is made.

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

The preceding allocation of proceeds will be paid from the first dollar of any proceeds received and will have a priority over competing claims regardless of whether the total amount of the recovery of the eligible person, or those claiming under him, is less than the actual loss suffered, or less than the amount necessary to make the eligible person, or those claiming under him, whole. The Fund's rights will not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Garrity Doctrine," "Rimes Doctrine," or any doctrine purporting to defeat the Fund's rights by allocating the proceeds exclusively, or in part, to non-medical expense damages.

Furthermore, such allocation will apply to claims of dependents of eligible employees covered by the Fund, regardless of whether such recipient was legally responsible for expenses of treatment.

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

RIGHT OF RECOUPMENT

Whenever the Plan has made unauthorized payments or payments in excess of the maximum amount applicable at that time for any reason, the Plan has the right to recover such unauthorized payments or overpayments from one or more of the following sources:

1. any person to, or for, or with respect to whom such payments were made, including by making deductions from benefits which may be payable to or in behalf of such a person in the future; or

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

PHYSICAL EXAMINATIONS AND AUTOPSY

Trustees, at their own expense, have the right and opportunity to have any individual whose injury or sickness is the basis for a claim, to be medically examined as often as the Trustees may reasonably require during the pendency of a claim. They also have the right to have an autopsy performed where it is not forbidden by law.

If you refuse to submit to a physical examination as requested, Trustees may deny benefits. In addition, if you do submit to a requested exam but you then refuse to follow the resulting recommended treatment plan, Trustees also may deny benefits.

GENERAL EXCLUSIONS

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

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

1. Any injury or sickness:

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

    b. which is work-related but the employer is not covered by or subject to the W.C. Act; or

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

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

    Trustees may, however, in their sole discretion, provide Plan benefits to eligible persons in cases in which:

    a. a question has arisen as to whether or not such injury or sickness is occupational or work-related and covered by the W.C. Act; and

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

c. the eligible person executes in favor of Trustees an enforceable written undertaking, satisfactory to and approved by counsel for the Fund, stating that if the DWD (or a similar agency in another state) or the courts determine or render a decision that the injury or sickness is, in fact, covered by the W.C. Act, or if a compromise settlement as to such issue is approved by the DWD, then the eligible person will reimburse and repay to the Fund all benefits paid by the Fund to the eligible person for such injury or sickness.

Failure by the eligible person to comply with the reimbursement as defined in the preceding paragraph c. allows the Fund, at its discretion, to either:

a. take a credit against future claims of the eligible person up to the amount of the Fund's expenditures of such expense;

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

c. exercise the Fund's right to reimbursement, including but not limited to claims for restitution, unjust enrichment, or a constructive trust over any recovery by the eligible person, to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, the eligible person, the eligible person's attorney, or any other individual or entity.

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

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

3. Expenses incurred for care for non-service-connected conditions furnished within any facility of, or provided by, the United States Department of Veterans Affairs or Department of Defense for which there has not been furnished to the Fund Office required details and supporting papers.

4. Injury or sickness caused by war or any act of war (declared or undeclared).

5. Loss incurred while engaged in military service (including naval or air service).

6. Elective procedures unless specifically included, but in no event elective procedures for cosmetic reasons unless specifically included under the Plan for the repair or reconstruction of injuries within 12 months of the date of the injury or breast reconstruction following mastectomy.

7. Expenses the patient otherwise is not required to pay.

8. A dependent child's pregnancy, including resulting childbirth, miscarriage, or complications except for preventive services for women as required by the Affordable Care Act.

9. Expenses for services and supplies which are not incurred for the actual treatment of an injury or sickness, such as those provided for developmental deficiencies as defined on page 78 and those incurred for emergency care for nervous and mental disorders, alcoholism, and substance abuse when no actual treatment is rendered.

10. Charges for artificial life support in excess of $5,000 or incurred more than five days after legal or clinical death.

11. Medical expenses incurred in an automobile accident if automobile insurance was not obtained by the eligible person as required by state law. (Payment will be considered on the amount that exceeds no-fault coverage.)

12. Charges for elective termination of pregnancy, unless specifically included under the Plan.

13. Psychological testing, except as specifically stated.

14. Alternative medicine.

15. Aggregate costs in excess of $5,000 for experimental medical treatment and procedures, except specifically as may be provided for under the Plan or as may be authorized by the Board of Trustees pursuant to advice provided by a physician retained by Trustees as medical consultant.

16. Expenses incurred for services, treatment, or surgical procedures rendered in connection with an overweight condition or condition of obesity including prescription drugs, diet plans, and related physician visits, unless specifically included under the Plan.

17. Charges for medical services and treatment outside of the United States will be excluded unless incurred for care of an emergency condition as determined by the Plan. An "emergency condition" means the sudden and unexpected onset of a change in an eligible person's physical or mental condition which, if not treated immediately, could reasonably be expected to result in the following as determined by the Plan:

    a. loss of life or limb;

b. significant impairment to bodily function; or

c. permanent dysfunction of a body part.

Treatment of emergency conditions rendered outside the United States that fall within these parameters will be payable subject to the Plan's deductible and copayment provisions and will be limited to charges deemed reasonable in the United States. Such charges must be submitted in English.

18. Sexual reassignment surgery, services, counseling, or supplies.

19. Charges incurred by an eligible person for the reversal or attempted reversal of a previous sterilization procedure.

20. Genetic testing, therapy, and engineering except as specifically provided. Genetic testing to determine carrier status.

21. State and local taxes incurred on covered expenses.

22. Shipping and handling for charges incurred on covered expenses.

23. Charges incurred for the completing of claim forms (or forms required by the Plan for the processing of claims) by a physician or other provider of medical services or supplies.

24. Complications resulting from a procedure or surgery that is excluded under the Plan, including but not limited to, obesity and aesthetic cosmetic surgery.

25. Any drug or medicine which has not been approved by the United States Food and Drug Administration by issuance of a New Drug Application or other formal approval.

26. Any medical or surgical procedure which is not considered a generally accepted procedure by the medical community in the United States.

27. Services provided by a person who ordinarily resides in your home or is a family member.

28. Custodial care and maintenance care.

29. Any artificial means to achieve pregnancy, including but not limited to, invitro fertilization, GIFT, artificial insemination, and all related fertility testing and treatment, except as specifically provided.

30. Charges incurred for any special education rendered to any eligible person regardless of the type of education, except as specifically stated.

31. Charges for telephone conversations/telephone consultations.

32. Any losses incurred by an eligible person or dependent at a time that an eligible person owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by an eligible person, or where such person has failed to honor the Plan's right of subrogation or reimbursement or otherwise failed to cooperate with the Plan as specified.

33. Charges incurred for home births.

34. Immunizations, except as described under "Covered Immunizations." Immunizations for the purpose of travel or employment, or required because of where you reside, or any other reasons not listed, are not covered.

35. Charges incurred for a surrogate pregnancy.

36. Therapies or testing for learning disabilities.

37. Non-emergency transport, except as specifically stated.

38. Replacement supplies used with durable medical equipment, except as specifically stated.

39. Replacement of lost or stolen equipment.

40. Rentals of durable medical equipment that exceed the purchase price.

41. Replacement of lost or stolen medications or medications confiscated or seized by Customs or other authorities.

42. Any charges for physical exams or preventive care, regardless of purpose, beyond the amount stated in the Schedule of Benefits, unless specifically stated.

43. Skilled nursing facility services or confinement: for treatment of mental health conditions or mental retardation; when primary use of the facility is as a place of residence; when treatment is primarily custodial.

44. Charges for missed appointments.

45. Nutritional counseling, except for diabetes management.

46. Panniculectomy or removal of excess skin due to weight loss, weight loss surgery, or pregnancy, except as specifically stated.

47. Medications, meal plans, exercise programs for weight control or weight loss.

48. Bariatric surgical procedure(s) for obesity or morbid obesity and complications following bariatric surgery.

49. Circumcision, unless determined to be medically necessary for a medical condition.

50. Equipment not primarily intended to improve a medical condition or injury, including but not limited to: air conditioners or air purifying systems, arch supports, communication aids, elevators, exercise equipment, massage devices, overbed tables, commodes, toilet seat raisers, bath benches or chairs, sanitary supplies, telephone alert systems, vision aids, whirlpools, portable whirlpool pumps or sauna baths, standers, strollers.

51. Expenses related to normal activities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.

52. Homemaker, chore work, or housekeeping services.

53. Habilitation.

54. Long-term care.

55. Private-duty nursing.

56. Routine foot care.

TERMINATION OF PLAN

This Plan may be terminated:

1. in its entirety--by Trustee action and when Trustees determine that the Trust Fund is inadequate to carry out the intent and purpose of the Trust Agreement or is inadequate to meet the payments due, or to become due, to employees and/or dependents under the Trust Agreement or under the Plan Document;

2. as to employees (and their dependents) in a particular collective bargaining unit--by agreement of the union(s) and employer association (or individual employers, where applicable) which negotiate the labor agreements covering such collective bargaining units; or

3. for a particular employer and his non-bargaining unit or alumni employees--Trustees determine that an employer, signatory to a participation agreement to cover non-bargaining unit or alumni employees, no longer meets the requirements of such participation agreement and related policies.

In the event of termination, Trustees will:

1. make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and the expenses incidental to such termination;

2. arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their Trusteeship;

3. apply the Trust Fund to pay any and all obligations of the Trust and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Trust and the requirements of law; and

4. give any notices and prepare and file any reports which may be required by law.

No employer will directly or indirectly receive any refund of contributions upon termination of the Trust Fund.

PROHIBITION AGAINST ASSIGNMENT TO PROVIDERS

You, as an eligible person, participant, or beneficiary, may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. The prohibition against assignment of such rights includes, but is not limited to, the right to:

1. receive benefits;

2. claim benefits in accordance with Plan procedures and/or federal law;

3. commence legal action against the Plan, Trustees, Fund, its agents, or employees;

4. request Plan documents or other instruments under which the Plan is established or operated;

5. request any other information that a participant or beneficiary as defined in Section 102 of ERISA may be entitled to receive upon written request to a Plan Administrator; and

6. any and all other rights afforded an eligible person, participant, or beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

This provision does not have the effect of prohibiting the claims administrator or Trustees from mailing payment of benefits under the Plan directly to a provider of services or supplies.

PRIVACY POLICY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to protect the confidentiality of your protected health information, including electronic protected health information. Generally, health information means any information, whether oral or recorded in any form or medium, that is created or received by a covered entity such as the Plan, and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or your past, present, or future payment for the provision of health care. By law, you have a right to adequate notice of the uses and disclosures of your protected health information that may be made by the Plan, and of your rights and the Plan's legal duties with respect to your protected health information. The Plan's Privacy Practices Notice which follows on pages 68 through 74 sets forth your rights under HIPAA's privacy rules and regulations and the Plan's privacy policies and procedures.

HIPAA SECURITY REGULATIONS

The Plan has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information in electronic form that it creates, receives, maintains, or transmits in behalf of the Plan. Trustees will report to the Plan any security incident of which they become aware. The Plan's agreements with its business associates will require that the electronic, physical, and technical security of electronic protected health information be maintained. Any disclosures of electronic protected health information to Trustees are supported by reasonable and appropriate security measures.

COMPLIANCE WITH INTERNAL REVENUE CODE SECTIONS 105 AND 106

The Plan will take sufficient measures to preserve the tax-favored advantages provided by Code Sections 105 and 106.

GENETIC INFORMATION NONDISCRIMINATION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its Privacy Rules grant certain rights to participants and beneficiaries of the North Central States Regional Council of Carpenters' Health Fund (the "Plan") in relation to their medical information (called "protected health information"). This Privacy Practices Notice discusses those rights and obligations.

The Plan may use and disclose your protected health information without your permission for treatment, payment, and health care operations activities and, when required or authorized by law, for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

The Plan may disclose your protected health information to your family members, friends, and others involved in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

IMPORTANT NOTE: The Plan reserves the right to provide your protected health information to any person identified by you (such as a Business Agent), or whom the Plan in good faith believes was identified by you, or to a family member, other relative, or close personal friend. For example, the Plan may disclose your protected health information to your spouse if the spouse contacts the Plan to help resolve a payment issue on your behalf. The Plan only will provide protected health information in such a situation if it is directly relevant to such person's involvement with your care or payment related to your health care. If you object to such disclosures, please express your written objection to the contact person listed at the end of this notice.

The Plan may disclose to the sponsor of the Plan, the Board of Trustees of the North Central States Regional Council of Carpenters' Health Fund (the "Board of Trustees") whether you are enrolled or disenrolled in the Plan, summary health information for certain limited purposes, and your protected health information for the Board of Trustees to administer the

Plan if the Board of Trustees explains the limitations on its use and disclosure of your protected health information in the Plan Document.

The Plan otherwise will not use or disclose your protected health information without your written authorization.

You have the right to examine and receive a copy of your protected health information, to receive an accounting of certain disclosures the Plan may make of your protected health information, and to request that the Plan amend, further restrict use and disclosure of, or communicate in confidence with you about your protected health information.

You have the right to receive notice of breaches of your unsecured protected health information.

Please review this entire notice for details about the uses and disclosures the Plan may make of your protected health information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

The Plan's Legal Duties

The Plan is required by applicable federal and state law to maintain the privacy of your protected health information. The Plan also is required to give you this notice about its privacy practices, its legal duties, and your rights concerning your protected health information. The Plan must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect February 17, 2010, and will remain in effect unless the Plan replaces it.

The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. The Plan reserves the right to make any change in its privacy practices and the new terms of its notice applicable to all protected health information that the Plan maintains, including protected health information the Plan created or received before the Plan made the change. Before the Plan makes a significant change in its privacy practices, the Plan will change this notice and send the new notice to its then-current participants as required by law.

Uses and Disclosures of Your Protected Health Information

Treatment: The Plan may disclose your protected health information, without your permission, to a physician or other health care provider to treat you.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your x-rays from the treating radiologist.

Payment: The Plan may use and disclose your protected health information, without your permission, to pay claims from physicians, hospitals, and other health care providers for services delivered to you that are covered by the Plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the participant of the Plan through whom the participant or beneficiary

participates or initially participated, to a person other than yourself (such as your spouse or parent) for payment activities and the like.

The Plan may disclose your protected health information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

For example, the Plan may tell a physician whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health Care Operations: The Plan may use and disclose your protected health information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing, and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- rating the risk and determining the necessary funding levels for the Plan, and obtaining stop-loss and similar reinsurance for the Plan's health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying protected health information, and creating limited data sets for health care operations, public health activities, and research.

The Plan may disclose your protected health information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the protected health information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention. Disclosures for health care operations can include disclosures to a person other than you (such as your spouse or parent).

For example, the Plan may use information to project future benefit costs or audit the accuracy of claims processing functions.

Your Authorization: You may give the Plan written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give the Plan a written authorization, the Plan will not use or disclose your protected health information for any purpose other than those described in this notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: The Plan may disclose your protected health information to a family member, friend, or any other person you involve in your health care or payment for your health care. The Plan will disclose only the protected health information that is relevant to the person's involvement.

The Plan may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts. Before the Plan makes such a disclosure, the Plan will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, the Plan will use its professional judgment to determine whether disclosing your protected health information is in your best interest under the circumstances.

Disclosures to the Board of Trustees: The Plan may disclose to the Board of Trustees whether you are enrolled or disenrolled in the Plan. The Plan may disclose summary health information to the Board of Trustees to obtain premium bids for health insurance coverage offered or that will be offered under the Plan or to decide whether to modify, amend, or terminate the Plan. Summary health information is aggregated claims history, claims expenses, or types of claims experienced by the enrollees in the Plan. Although summary health information will be stripped of all direct identifiers, it still may be possible to identify protected health information contained in the summary health information as yours.

The Plan may disclose your protected health information and the protected health information of others enrolled in the Plan to the Board of Trustees to administer the Plan. Before the Plan may do that, the Board of Trustees must amend the Plan Document to establish the limited uses and disclosures the Board of Trustees may make of your protected health information. Please see the Plan Document for a full explanation of those limitations.

Health-Related Products and Services: The Plan may use your protected health information to communicate with you about health-related products, benefits and services, and payment for those products, benefits, and services that the Plan provides or includes, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in the Plan's network, if any, about replacement of or enhancements to the Plan, and about health-related products or services that are available only to the Plan's enrollees that add value to, although they are not part of, the Plan.

Public Health and Benefit Activities: The Plan may use and disclose your protected health information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect, or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state Worker's Compensation laws.

Individual Rights

Access: You have the right to examine and to receive a copy of your protected health information, with limited exceptions. You must make a written request to obtain access to your protected health information. Submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

The Plan may charge you reasonable, cost-based fees for a copy of your protected health information, for mailing the copy to you, and for preparing any summary or explanation of your protected health information you request. Contact the Plan using the information at the end of this notice for information about these fees.

Disclosure Accounting: You have the right to a list of instances after April 13, 2003, in which the Plan disclosed your protected health information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. The Plan will provide you with information about each accountable disclosure that the Plan made during the period for which you request the accounting, except the Plan is not obligated to account for a disclosure that occurred more than six years before the date of your request and never for a disclosure that occurred before April 14, 2003. If you request this accounting more than once in a 12-month period, the Plan may charge you a reasonable, cost-based fee for responding to your additional requests. Contact the Plan using the information at the end of this notice for information about these fees.

Amendment: You have the right to request that the Plan amend your protected health information. Your request must be in writing and it must explain why the information should be amended. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

The Plan may deny your request only for certain reasons. If the Plan denies your request, the Plan will provide you a written explanation. If the Plan accepts your request, the Plan will make your amendment part of your protected health information and use reasonable efforts to inform others of the amendment who the Plan knows may have relied on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that the Plan restrict its use or disclosure of your protected health information for treatment, payment, or health care operations, or with family, friends, or others you identify. The Plan is not required to agree to your request. If the Plan does agree, the Plan will abide by the agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

Any agreement the Plan may make to a request for restriction must be in writing signed by a person authorized to bind the Plan to such an agreement. Effective February 17, 2010 (or such later date specified by the U.S. Department of Health and Human Services), the Plan will agree to a restriction request if:

- except as otherwise by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and
- the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

Confidential Communication: You have the right to request that the Plan communicate with you about your protected health information in confidence by means or to locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

The Plan will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit the Plan to collect contributions and pay claims. Please note that an explanation of benefits and other information that the Plan issues to the participant about health care that you received for which you did not request confidential communications, or about health care received by the participant or by others covered by the Plan, may contain sufficient information to reveal that you obtained health care for which the Plan paid, even though you requested that the Plan communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured protected health information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your protected health information, the notice will be provided to your next of kin or personal representatives if the Plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on the Plan's website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact the Plan using the information at the end of this notice to obtain this notice in written form.

State Law: As a condition of Plan participation, the Board of Trustees requires that the privacy rights of you, your spouse, and dependents be governed only by HIPAA and the laws of the State of Wisconsin (but only to the extent such laws are not preempted by the Employee Retirement Income Security Act of 1974, as applicable), without regard to whether HIPAA incorporates privacy rights granted under the laws of other states and without regard to Wisconsin's choice of law provisions.

Questions and Complaints

For more information about the Plan's privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact the Plan using the information at the end of this notice.

If you are concerned that the Plan may have violated your privacy rights, or you disagree with a decision the Plan made about access to your protected health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence

about your protected health information (including a breach notice communication), you may complain to the Plan using the contact information at the end of this notice.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

The Plan supports your right to the privacy of your protected health information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Contact Person: Plan's Privacy Official

Telephone: (715) 835-3174, local
1-800-424-3405, toll-free

Address: North Central States Regional Council of Carpenters' Health Fund
P.O. Box 4002
Eau Claire, WI 54702

GENERAL DEFINITIONS

Whenever used in this Summary Plan Description, the following terms are understood to have the meanings described as follows.

Alumni means persons who once participated in the Plan because of work performed under a collective bargaining agreement requiring contributions to this Fund and who currently perform work which is not covered by such agreement for:

1. one or more employers that are parties to the collective bargaining agreement requiring contributions to the Fund;

2. the Plan; or

3. the union.

Bargaining Unit Employee means any employee represented by the union and working for an employer (as defined in the Trust Agreement), and with respect to whose employment an employer is required to make contributions to the Trust Fund.

Calendar Year means that period commencing at 12:01 a.m. central standard time on the date the eligible person first becomes eligible and continuing until 12:01 a.m. central standard time on the following January 1st. Each subsequent calendar year will be the period from 12:01 a.m. central standard time on January 1st to 12:01 a.m. central standard time on the next following January 1st. The time will be that time at the address of Trustees.

Chiropractor means a licensed chiropractor operating within the scope of such license.

Classes of Eligible Persons means all the classifications of coverage under the Plan as follows:

Class C (Active): Employees (and their dependents) of employers obligated by a collective bargaining agreement to pay contributions to this Fund.

The term “employees” includes bargaining unit employees and, provided the employer is party to an approved participation agreement, certain non-bargaining unit or alumni employees.

Class O (Active Employees of Industrial Employers): An Industrial Employer’s bargaining unit and non-bargaining unit employees (and their dependents) who satisfy the applicable Eligibility Rule requirements.

Class E and G (COBRA):

1. *Class E* – An eligible person continuing coverage for Comprehensive Major Medical Benefits through COBRA self-payments.

2. *Class G* – An eligible person continuing coverage for Comprehensive Major Medical Benefits, Vision Care Benefits, and Dental Care Benefits through COBRA self-payments.

Class P, R, S, T, U, and V (Retired): Retired employees and their dependents (both those who are eligible for Medicare and those who are not) continuing coverage through self-payments according to the Eligibility Rules.

Please Note: Early retirees/spouses who become initially entitled to Medicare due to End Stage Renal Disease will remain in an early retiree Class (R or P) until the full 30-month coordination period specified in the Medicare Provisions on page 56 has elapsed (even if such person turns age 65 during that period).

Medicare-eligible retirees and/or spouses in Classes U, S, V, and T who cover children under age 26 will have their self-payment amount based at the level required for retired employees and spouses who are not Medicare-eligible (Classes R and P).

Covered Employment means employment in covered work for a participating employer.

Covered Work means the type of work covered by a participating union's building, construction, and industrial labor contracts.

Dental Hygienist means any person who is currently licensed (if licensing is required in the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene, and who works under the supervision of a dentist.

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

Dependent means the eligible employee's spouse (except if legally separated) and child or children under age 26 who are younger than the eligible employee (except for subsection 5).

When both husband and wife are employed by the same or another employer and are eligible employees under this Plan, each will be covered under the Plan as an employee but also will be eligible for coverage as a dependent of their respective spouse. Children may be covered as dependents of both the husband and wife. When an employee is under the age of 26 and has one or two parents also covered under the Plan, the employee will be eligible for coverage as a dependent under the parents' Plan. Benefits are payable according to the coordination of benefits provision on page 54.

The term "child" or "children" also includes:

1. Legally adopted children who meet the specified age restrictions. With respect to an adopted child, the child is a dependent under this definition effective on the date of placement with you.

2. Stepchildren who meet the specified age restrictions. The Plan's obligation to provide benefits will be secondary to any obligation of either or both of the natural parents created by court order or judgment of divorce or of legal separation. The stepparent will promptly provide a copy of any such court order or judgment and,

in the event there is imposed such obligation on the natural parent or parents, the stepchildren first will seek payment or provision of benefits pursuant to said obligation of the natural parent(s). If collection under, or enforcement of, the natural parent's obligation is impossible or impracticable, the Plan will provide benefits the same as for legally adopted children according to the terms and conditions of the Plan Document. The Fund will be assigned the right to enforce such obligation so as to obtain reimbursement from the responsible natural parent or parents, or from their insurer, for benefits provided.

3. Foster children who meet the specified age restrictions and are placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

4. Grandchildren who are under age 19 or under age 23 as long as their primary activity is that of a full-time student enrolled in and attending classes in an accredited school. Grandchildren must: receive more than one-half their annual financial support from you; have the same principal residence as you for more than one-half the calendar year except for temporary absences; and be a lineal dependent.

5. Children, regardless of age, who are incapable of self-sustaining employment by reason of mental retardation or physical handicap and such incapacity began prior to age 19. The Fund will continue the health coverage for such child so long as the employee's coverage remains in force and such incapacity continues. Proof of the incapacity must be submitted to Trustees within 31 days of the date such dependent child's coverage otherwise would terminate due to attainment of age 19 or, in the case of a newly eligible employee, within 31 days after the employee first becomes eligible under the Plan. Such 31-day period may be extended by Trustees for good cause as determined by Trustees.

6. A child who is named in a Qualified Medical Child Support Order as an alternate payee with which you and the Fund are obligated to comply.

A child of an eligible employee must be a citizen or resident of the United States. This provision does not exclude an adopted child who does not meet the citizenship criteria if the child has the same principal residence as the eligible employee, is a member of the eligible employee's household, and the eligible employee is a citizen or national of the United States.

Trustees will recognize their obligation to comply with Qualified Medical Child Support Orders under applicable federal regulations.

This definition is meant to be consistent with IRS Rules.

Developmental Care means care primarily related to assisting in the development of those skills related to developmental deficiencies and not rehabilitative in nature. This care is not an effort to restore previously developed skills that were lost or impaired due to injury or sickness.

Developmental Deficiency means conditions which prevent persons from reaching the level of intellectual, speech, motor, or physical development normally expected for the person's age.

Eligible Employee means any employee or former employee of an employer who is eligible for benefits in accordance with the applicable Eligibility Rules of the Fund as adopted from time to time.

Eligible Person means either the eligible employee or the eligible dependent.

Essential Health Benefits generally means items and services covered within the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.

Please Note: Government agencies have not yet issued specific guidance on what constitutes "essential health benefits," so the Trustees have made a good faith effort to comply with a reasonable interpretation based on the information available at the time of this SPD printing.

Experimental means those treatments, procedures, drugs, and devices that have not yet gained acceptance by the medical community as standard therapy at the time the service is rendered. Experimental treatments are those that are characterized by at least one of the following at the time of treatment:

1. The treatment is undergoing clinical investigation and is not generally recognized by the medical community as established and accepted practice.

2. The treatment has not yet been approved by the Food and Drug Administration or other governmental agency.

3. Any treatment which is: of uncertain therapeutic benefit; restricted to use in clinical trials; or of questionable safety and effectiveness for the eligible person's condition.

Fiscal Year means the 12 months beginning any January 1st and ending the following December 31st.

Home Health Care Agency means a public or private organization which is primarily engaged in providing skilled nursing and therapeutic services on an at-home basis. A home health care agency must be supervised by professional medical personnel and be licensed or approved by the state or locality in which it operates.

Hospice Program means programs which:

1. have received necessary authorization from the Health Systems Agency to initiate hospice care in a given area;

2. are eligible to satisfy accreditation requirements as developed by the National Hospice Organization and/or the Joint Commission on the Accreditation of Health Care Organizations; and meet the following criteria:

    a. The patient and family are seen as the unit of care.

    b. An integrated, centralized, administrative structure ensures continuity of care for home care and inpatient care.

    c. Volunteers are used to assist paid staff members.

    d. Direct provision of care is provided by an interdisciplinary team consisting of physicians, nurses, social workers, chaplains, and volunteers.

    e. 24-hour-per-day, 7-day-per-week service is available.

Hospital means a place which is licensed as a hospital (if licensing is required by law), which is operated for the care and treatment of resident inpatients and which has a laboratory, registered nurses continually on duty, and an operating room where major surgical operations are performed by physicians. In no event will the term "hospital" include an institution or that part of an institution which is used principally as a clinic, convalescent home, rest home, nursing facility, or home for the aged. Hospital also means an institution which has accommodations for resident bed patients, facilities for the treatment of nervous or mental disorders, and a resident psychiatrist on duty. Hospital further includes institutions specializing in the treatment of alcoholism or substance abuse, provided the institution is licensed by the governmental authority if licensing is required. To be covered, these hospitals also, as a regular practice, must charge patients for the expense of confinement.

Industrial Employee means a bargaining unit employee of an Industrial Employer or a non-bargaining unit employee of an Industrial Employer who has entered into a participation agreement with the Board of Trustees and such participation agreement has been approved by Trustees.

Injury means accidental bodily damage which requires treatment by a physician and which results in loss independently of sickness and other causes. For the purposes of Accident and Sickness Weekly Benefits, only an employee's absence from work which immediately follows the date of the original injury will be considered for benefits beginning on the first day of the disability. Related symptoms and recurrent symptoms of the injury will be considered a disability caused by a sickness and considered for Accident and Sickness Weekly Benefits beginning on the eighth day of the disability.

Intensive Care Unit means a special area of a hospital exclusively reserved for critically ill patients requiring constant observation which, in its normal course of operation, provides:

1. personal care by specialized registered nurses and other nursing care on a 24-hour-per-day basis;

2. special equipment and supplies which are immediately available on a standby basis; and

3. care required but not rendered in the general surgical or medical nursing units of the hospital.

The term “Intensive Care Unit” also will include an area of the hospital designated and operated exclusively as a Coronary Care Unit, Cardiac Care Unit, or Neonatal Intensive Care Unit.

Lifetime, with reference to benefit maximums and limitations, means the aggregate covered expenses incurred while an eligible person is covered under the Plan. Under no circumstances will “lifetime” mean during the lifetime of an eligible person, even after the person’s eligibility ends.

Medically Necessary means a service or supply which:

1. is appropriate and consistent with the diagnosis of an injury or sickness in accordance with accepted standards of community practice; and

2. could not have been omitted without adversely affecting the person’s condition or the quality of medical care.

Non-Bargaining Unit Employees means an employer’s full-time employees who perform work which is not covered by a labor contract requiring contributions to this Fund and who, therefore, are not represented by a labor organization and who are not alumni. A full-time employee is one who is regularly employed by an employer 25 or more hours per week.

Optician, Optometrist, and **Ophthalmologist** means any person who is qualified and currently licensed (if licensing is required in the state) to practice each such profession by the appropriate governmental authority having jurisdiction over the licensure and practice of such profession, and who is acting within the usual scope of that practice.

Participant means any employee or former employee of an employer as defined in the Trust Agreement who is eligible to receive any benefit from this Fund in accordance with the Eligibility Rules or other regulations that Trustees may establish.

Participating Employer means an employer as defined in the Trust Agreement and who is required to pay contributions to the North Central States Regional Council of Carpenters’ Health Fund pursuant to a collective bargaining agreement or an approved participation agreement.

Personal Pronoun Usage. Words used in this SPD in the masculine or feminine gender will be considered as the feminine gender or masculine gender respectively, where appropriate.

Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

Physician means a person who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of such practice. “Physician” will be interpreted to include, but will not be limited to, a doctor of medicine, osteopath, podiatrist, chiropodist, ophthalmologist, and doctor of dental surgery.

Plan means the document adopted by Trustees, as amended from time to time, which incorporates the provisions, terms, and conditions under which benefits are paid and the schedules of benefits which are in effect.

Plan Year means the 12 months beginning any January 1st and ending the following December 31st.

Preauthorization means it is recommended that certain procedures/services are reviewed for medical necessity and approved for coverage BEFORE they are performed.

Precertification means the participant, physician, or hospital must notify CMS when an eligible person is scheduled for a non-emergency inpatient admission.

Preferred Providers means:

1. physician, dentist, registered nurse, physical therapist, or other licensed health care provider;

2. hospital;

3. alcohol and substance abuse treatment facility;

4. hospice;

5. laboratory;

6. outpatient surgical facility;

7. pharmacy;

8. business selling or renting durable medical equipment; or

9. any other source,

who/which alone or as part of a group enter into a contract with Trustees agreeing to be compensated for those services and supplies covered under this Plan according to the terms of such contract. Such parties are preferred providers for the duration of their contract.

The types of preferred providers currently include the following:

"Preferred Provider Pharmacy (PPRx)" means a pharmacy which participates in the Preferred Provider Pharmacy Program and is party to a contract with Trustees. Currently, Trustees have a contract with Express Scripts under which: retail stores participating in the nationwide Express Scripts network (excluding Wal-Mart Pharmacies) are the designated Preferred Provider Pharmacies; and Express Scripts is the designated Mail-Service Preferred Provider Pharmacy.

"Preferred Provider Network" means any of the hospitals, physicians, or other health care providers which contract with Trustees directly or through their agents from time to time. Anthem Blue Cross and Blue Shield is the preferred provider network. In addition, the Fund has a direct contract arrangement with Dean Health Systems/St. Mary's Ventures in the Madison, WI area.

"Preferred Provider Optical Center" means the optical center which is party to a contract with Trustees, currently ShopKo Optical.

"Preferred Provider Preventive Care Program" means the organization which contracts with Trustees from time to time to provide preventive care services, currently Health Dynamics. Contact the Fund Office for the most current listing of locations where you may have the physical performed.

Prevailing Contribution Rate means the hourly contribution rate determined by the Board of Trustees as needed to support the benefit plan Trustees adopt for active employees performing covered employment.

Employer contribution rates required pursuant to such labor contracts with unions and which are less or greater than the "prevailing contribution rate" will be prorated when crediting contributions for purposes of determining active employees' eligibility and the need for self-payments, unless a reciprocity agreement dictates otherwise.

Qualified Medical Child Support Order (QMCSO) means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law which has the force and effect of law under applicable state law, that:

1. provides for child support payments related to health benefits with respect to the child of a Plan participant, or requires health benefit coverage of such child by the Plan, and is ordered under such state domestic relations law; or

2. enforces a state law relating to medical child support payments with respect to the Plan; and

3. creates or recognizes the right of a child as an alternate recipient--who is recognized under the order as having a right to be enrolled under the Plan--to receive benefits derived from such child's relationship to an eligible employee who is a participant in the Plan; and

4. includes the name and last known address of the participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided; and

5. does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; and

6. has been determined to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Fund Office upon request at no charge.

Under federal law, the Plan must recognize Qualified Medical Child Support Orders (QMCSOs) which provide benefits for a dependent child or children as determined by a court order in the event of a divorce or family law action. Orders must be submitted to the Fund Office who will determine whether the Order meets the requirements for QMCSOs under federal law. By calling the Fund Office, participants and beneficiaries may obtain a free copy of the Plan's procedures for reviewing QMCSOs entitled, "North Central States Regional Council of Carpenters' Health Fund Qualification of Medical Child Support Orders - Guidelines for Attorneys and Parties-in-Interest." When the Fund Office receives an order, the Fund Office will promptly notify you and each alternate recipient of the receipt of the order and then provide you with a copy of the Guidelines for determining whether it is a QMCSO.

Reasonable Expense means the charges incurred for services and supplies which are medically necessary for treatment and which are regular and customary as determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned. Reasonable expenses for medical procedures are based on the 90th percentile reflected in the Fair Health schedule of prevailing medical charges.

Self-Funded Plan means a group health care plan in which the Fund assumes the financial risk for providing health care benefits to its employees. Instead of paying a fixed premium to an insurance company to pay the claims, a self-funded Plan directs employer contributions, self-payments, and investment earnings into a Trust Fund that is overseen by strict federal government regulation. The Plan pays claims directly from accumulated Trust Fund assets.

Sickness means a disease, disorder, or condition which requires treatment by a physician, including pregnancy and childbirth and any related conditions (but excluding a dependent child's pregnancy, childbirth, and complications except for preventive services for women as required by the Affordable Care Act).

Skilled Nursing Facility means a specially qualified facility that has staff and equipment to provide:

1. skilled nursing care performed by, or under the supervision of, licensed nursing personnel;

2. skilled rehabilitation services, such as physical therapy, performed by, or under the supervision of, a professional therapist; and

3. other related health services.

Subrogation/Reimbursement means the Fund's right to recover Plan benefits from another party or the participant or a dependent of the participant.

Total Disability:

1. As used in regard to Accident and Sickness Weekly Benefits, the term "Total Disability" means any disability commencing while the eligible employee is covered under the Plan and resulting from injury or sickness which prevents the eligible employee from performing any and every duty pertaining to his occupation, including "light work." To be considered as having a "Total Disability," the eligible employee must not be receiving remuneration for any other work or service.

2. As used for purposes other than that stated in the prior paragraph 1., the term "Total Disability" means an injury or sickness commencing while the eligible person is covered under the Plan which prevents an eligible person from engaging in gainful employment.

Totally and Permanently Disabled: an employee will be considered "Totally and Permanently Disabled" upon receipt of a disability benefit from the North Central States Regional Council of Carpenters' Pension Fund or another construction industry pension fund.

Trust Fund or **Fund** means the entire trust estate of the North Central States Regional Council of Carpenters' Health Fund as it may, from time to time, be constituted.

Trustees means Trustees of the North Central States Regional Council of Carpenters' Health Fund.

Uniformed Services means the United States Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

You means any participant.

The terms **"Beneficiary," "Employee," "Employer," "Trust Agreement,"** and **"Union"** have the same meaning in this Summary as they do in the Restated Trust Agreement, currently in effect, as amended, and are incorporated by reference.

HOW TO APPLY FOR BENEFITS

PRE-SERVICE CLAIMS:

It is recommended that you obtain preauthorization for certain services and supplies as specified on page xviii or Plan benefits will be denied if determined not to be medically necessary. Precertification is required for any non-emergency hospital confinement, any non-emergency inpatient surgery, and certain outpatient surgeries to be eligible for the maximum level of benefits. Also, you must contact the Fund Office for prior approval for all organ transplants. Claims such as this are called, "pre-service claims," which means any claim which requires approval of the benefit in advance of obtaining medical care. Pre-service claims may be submitted initially by telephone or in writing to the Fund Office.

There are special provisions in the Claims Procedure Regulations for "urgent care claims" (referred to under the Plan as "emergencies"), but, by definition, these provisions do not apply because the Plan does not require prior approval of emergency admissions.

POST-SERVICE CLAIMS:

Any claim for benefits that is not a pre-service claim is considered a "post-service claim." Post-service claims include those for emergency hospital admissions. You must notify the Plan within 48 hours following an emergency admission. You must submit all other post-service claims in writing within 90 days of the occurrence of the accident or sickness, or as soon thereafter as is reasonably possible. In no event (except in the absence of legal capacity) can a claim be submitted later than two years after the claim was required to be received by the Fund Office.

Claim forms can be downloaded from the Fund's website: www.ncscbf.com.

Once you become eligible, you will receive an identification card from the Fund which identifies you and contains the name and address of the North Central States Regional Council of Carpenters' Health Fund. The Fund's Administrative Manager certifies eligibility, processes claims, and makes the benefit payments. When you obtain health care services or supplies, make sure you present your ID card to the provider. Your ID card will give the provider all the information necessary to submit the claim for payment. If the provider does not submit the claim, you must do so yourself. Post-service claims must be submitted in writing to the appropriate party as follows:

Send all insured organ transplant claims to:

National Union Fire Insurance Company of Pittsburgh, PA
c/o Medical Excess
8777 Purdue Road, Suite 330
Indianapolis, IN 46268

Send all claims for dental, vision, and Medicare-eligible retirees to:

Fund Office
North Central States Regional Council of Carpenters' Health Fund
P.O. Box 4002
Eau Claire, WI 54702

Send all other medical claims for services obtained in Wisconsin to:

Anthem Blue Cross and Blue Shield
P.O. Box 34210
Louisville, KY 40232-4210

Send all other medical claims for services obtained outside Wisconsin to your local Blue Cross and Blue Shield Plan.

Claims should be complete, including, at a minimum:

1. Fund name (North Central States Regional Council of Carpenters' Health Fund);

2. employee's name and identification number;

3. full name (including "Jr.," if applicable) and date of birth of the eligible person who incurred the covered expense;

4. name and address of the service provider;

5. federal tax identification number of provider;

6. diagnosis of the condition;

7. procedure or nature of the treatment;

8. date of and place where the procedure or treatment has been provided;

9. amount billed and the amount of the covered expense not paid through coverage other than this Plan, as appropriate; and

10. evidence that substantiates the nature, amount, and timeliness of each covered expense that is in a reasonably understandable format and is in compliance with all applicable law.

Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address. A general request for an interpretation of Plan provisions will not be considered a claim for benefits. Pre-determined amounts you must pay, such as a prescription drug copayment or amount required because of use of a network or non-network provider, will not be considered a claim for benefits subject to the claims procedure. However, if you feel that you have been charged an improper dollar or percentage copayment (for example through the Preferred Provider Pharmacy Program), you may submit a formal appeal to the Fund Office in writing within 180 days to have your claim reviewed according to the appeal procedures stated on pages 88 through 96.

You or your authorized representative can pursue a claim. You may authorize a representative by submitting a written authorization to Trustees.

Benefits are paid directly to the provider of service, unless you direct otherwise in writing when the claim is submitted and you attach proof of payment.

ACCIDENT: If the claim you are submitting is the result of an accident, be sure to complete an injury form. Furnish the name and address of any third party who may be liable for hospital and medical costs related to an injury.

DEATH BENEFITS: To receive Death Benefit payments, your beneficiary or the executor of your estate must obtain a Death Benefit claim form from the Fund Office. Your beneficiary must complete the claim form, attach a certified copy of the death certificate, and submit both to the Fund Office.

ACCIDENT AND SICKNESS WEEKLY BENEFITS: To receive Accident and Sickness Weekly Benefits, obtain a disability claim form from the Fund Office. Complete your portion of the claim form and have your physician complete the physician's portion of the form. (If the physician's portion of the claim form is not complete, payment will be delayed.) Mail the completed form to the Fund Office.

You do not need to file any further claim forms, even if you continue to receive benefits for several weeks of disability. The Fund Office will obtain the required information directly from your physician. When benefit checks are issued to you, the Fund Office will request, from your physician, continuing dates of disability and ask whether you remain under the physician's care as required. Benefits then will be extended through the date of the physician's signature or until:

- you no longer are under the physician's care;
- you return to active employment; or
- the benefit is exhausted,

whichever occurs first.

CLAIMS APPEAL PROCEDURES

When you submit a pre-service claim, the Plan will notify you whether or not the claim is approved within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of the Plan's receipt of the claim. If you fail to follow the Plan's procedures for filing a claim, you will be notified of the failure and the proper procedures as soon as possible, but no later than five days following the failure. We will notify you verbally, unless you request us to notify you in writing. For organ transplants that are insured by National Union Fire Insurance Company of Pittsburgh, PA, National Union Fire Insurance Company of Pittsburgh, PA will notify you directly of their decision. You must appeal directly to such insurance company according to their grievance procedures; the Fund Office will be glad to assist you. The decision by such insurance company will be final and binding.

For post-service claims, the Plan will notify you of an adverse benefit determination within a reasonable period of time, but not later than 30 days of the Plan's receipt of a claim.

For both pre- and post-service claims, if the Plan needs additional time to determine whether a claim is a covered expense for reasons beyond the Plan's control, the Plan may take one 15-day extension. The Plan will notify you prior to the expiration of the initial 15- or 30-day notification period, as applicable, of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If an extension is needed due to your failure to submit necessary information to decide the claim, the Plan, in the notice of extension, will specifically describe the required information needed. The time period for making the determination is suspended from the date on which the notice of the necessary information is sent to you until the date you respond. You have 45 days from receipt of the notice to respond to the request for information. Once you respond, the Plan will decide the claim within the 15-day extension period. Your claim will be denied if you do not respond in a timely manner. The Plan may take only one extension for group health claims and may not further extend the time for making its decision unless you agree to a further extension.

A concurrent care claim is a claim that is reconsidered after the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and the reconsideration results in the reduction or termination of the treatment (other than by Plan amendment or termination) before the scheduled end of the treatment. If the Plan reduces or terminates treatment before the end of the course of the treatment, the Plan will notify you far enough in advance of the termination or reduction of treatment to allow you to appeal the adverse benefit determination and obtain a determination on review before the termination or reduction takes effect. The Plan must continue to cover the claimant for a concurrent care claim for ongoing treatment pending the outcome of an internal appeal.

For disability claims, the Plan has a reasonable period of time, not in excess of 45 days, to provide written notice of an adverse benefit determination for any claim for disability benefits under the Plan. The Plan may extend the decision-making period for up to an additional 30 days for reasons beyond the Plan's control but the Plan will notify you in writing before the expiration of the 45-day period of the reason for the delay and when the decision will be made. A second 30-day extension is allowable if the Plan still is unable to make the decision for reasons beyond its control. You will be provided, before the expiration of the first 30-day extension period, a notice that details the reasons for the delay and the date as of which the Plan expects to render a decision. If an extension is needed because the Plan needs additional information from you, the extension notice will specifically explain the standards on

which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and specify the additional information needed to resolve those issues, in which case you will have 45 days from receipt of the notification to provide the requested information. The Plan will issue its decision within 30 days of the date you submit your information (subject to the 30-day extension previously described). Your claim will be denied if you do not submit the requested information in a timely manner.

If the Plan denies coverage for your claim, the denial is called an adverse benefit determination as defined under the U.S. Department of Labor Regulations. An adverse benefit determination includes a rescission of your coverage under the Plan, except in the case of fraud or intentional misrepresentation of a material fact. The Regulations define a rescission as a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance only has a prospective effect. The following are not considered rescissions under the Regulations even though retroactive:

1. Retroactive termination to the extent attributable to failure to pay a timely premium (self-payment) towards coverage.

2. Retroactive elimination of coverage back to the date of termination of employment, due to delays in administrative recordkeeping if the employee does not pay any premiums for coverage after termination of employment.

3. The Plan's termination of coverage retroactive to the date of a divorce.

To clarify, this means that, in general, the Plan cannot terminate your coverage retroactively. However, the Plan may do so under the circumstances described and in other instances as may be prescribed in the Regulations. The Plan is required to provide at least 30 days advance written notice to each eligible person who is affected by a rescinding of coverage before the coverage may be rescinded.

If your claim for benefits is denied in whole or in part, the Administrative Manager will provide you, your dependent, beneficiaries, or authorized or legal representatives, as may be appropriate (hereafter referred to as "you" or "your") with written or electronic notice of adverse benefit determinations within the time frames previously stated. *The Plan must provide all notices to participants in a "culturally and linguistically appropriate" manner where 10% or more participants residing in a county speak the same non-English language (however, this provision does not apply to the Plan at this time).* Notices will include the following information stated in an easily understandable manner:

1. The specific reason or reasons for the adverse benefit determination.

2. References to specific Plan provision(s) on which the adverse benefit determination is based.

3. Information sufficient to identify the claim involved, including the date(s) of service; healthcare provider; claim amount; and diagnosis, treatment, and denial codes, including their corresponding meanings, upon request.

4. A description of any additional material or information, if any, necessary for you to perfect your claim and an explanation of why the material or information is necessary.

5. A description of the Plan's internal claims appeal procedures and time limits applicable to such appeal procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

6. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided free of charge to you upon request.

7. If the adverse benefit determination was based on a medical necessity or experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

8. If a medical or vocational expert's advice was obtained in behalf of the Plan in connection with your claim, you may request the identity of the expert, regardless of whether the advice was relied on.

The Plan will pay charges incurred for copies of medical records which have been requested by the Plan as necessary for processing a claim, whether it is determined that the Plan benefits are payable or denied.

If you feel that the action taken on your eligibility or claim is incorrect, you immediately should ask the Fund Office to review your claim with you. In some cases, the Fund Office may request additional information from you which might enable the Fund Office to reevaluate its decision.

Internal Claims Appeal Procedures

If all or part of a claim is denied or if you are otherwise dissatisfied with the determination made by the Plan, or if you have not received the notice of denial of your claim within the applicable time limits after the Plan has received all necessary claim information, you have the right to appeal the decision and request an internal review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

1. The Plan has three levels of appeal. The first level of appeal is decided by the Eligibility and Appeals Committee of the Trustees. The second level is decided by the Executive Committee of the Board of Trustees. The third level is the Federal External Claims Review Process and is decided by an Independent Review Organization (IRO). The rules regarding claims appeal procedures apply to the first and second levels of appeal, while the Federal External Claims Review Process has its own independent appeal procedure.

2. **You will have 180 days after you receive the notice of an adverse benefit determination to file your appeal in writing to the Fund Office and it must include the specific reasons you feel denial was improper.**

3. You will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits which may have been requested in the notice of denial or which you may consider desirable or necessary.

4. You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to your claim for benefits.

5. Your review will take into account all comments, documents, records, and other information submitted by you relating to the claim, whether or not such information was submitted or considered in the initial benefit determination.

6. The Plan will provide you, free of charge, any new or additional evidence or rationale considered, relied on, or generated in connection with an appeal and allow you to respond. Such information will be provided as soon as possible and sufficiently in advance of the date on which notice of the Plan's final adverse benefit determination must be provided.

7. The Plan will assign a decision maker on appealed claims that is an appropriate named fiduciary for the Plan and different than and not the subordinate of the person deciding the initial claim. The Plan will ensure that all claims and appeals are adjudicated with the utmost impartiality and avoid conflicts of interest. The claims or appeals adjudicator will be independent from and impartial to the Plan.

8. The Plan will consult with appropriate health care professionals in deciding appealed claims that are based in whole or in part on medical judgment, including determination of experimental or investigational treatments and medical necessity. Such health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted for the appeal of an adverse benefit determination will be someone who was not consulted in the initial adverse benefit determination nor the subordinate of such individual.

9. If a medical or vocational expert's advice was obtained in behalf of the Plan in connection with your claim, you may request the identity of the expert, regardless of whether the advice was relied on.

10. For appeals of pre-service claims, the Plan will notify you of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of receiving the first appeal request and 15 days of receiving the second appeal request, if applicable.

11. For appeals of post-service claims, the Plan will notify you of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days of receiving the first appeal request and 30 days of receiving the second appeal request, if applicable.

    The Plan will provide you with written or electronic notice of an adverse benefit determination as soon as possible but within five days of the decision being made. The notice will include the following information stated in an easily understandable manner:

    a. The specific reason or reasons for the adverse benefit determination.

    b. References to specific Plan provision(s) on which the adverse benefit determination is based.

    c. A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

    d. A statement of your right to an external review of the Plan's adverse decision by an IRO.

    e. A statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's claims appeal procedures, including an adverse decision by an IRO.

    f. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such criterion will be provided free of charge to you upon request.

    g. If the adverse benefit determination was based on a medical necessity or experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

Federal External Claims Review Process

If the Plan has denied your claim and issued you an adverse benefit determination under the internal claims appeal procedures, you have the right to appeal your decision externally. Only claims that involve medical judgment or a rescission of coverage are eligible for external review.

Standard External Review

Request for External Review: You may file a request for an external review within four months after the date you received notice from the Plan of a final adverse benefit determination.

Preliminary Review: The Plan must complete its preliminary review within five business days following receipt of the external review request to determine whether:

1. You were covered under the Plan at the time the health care service or item in question was requested, or in the case of a retrospective review, if you were covered under the Plan at the time the health care service or item was provided.

2. The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan and does involve a medical judgment or rescission of coverage.

3. You have exhausted the Plan's internal claims appeal procedures, unless you are not required to do so under the appeals rules.

4. You have provided all the information and forms required to process an external review.

5. Within one business day of completing its preliminary review, the Plan will notify you in writing if:

    a. Your request is eligible for external review.

    b. If your request is complete, but you are not eligible for an external review, the Plan will provide you with the reasons it has determined that you are ineligible for an external review and the contact information for the Employee Benefits Security Administration (toll-free: 1-866-444-3272).

    c. If your request is not complete, the notice will describe the missing information and materials needed to make the request complete. You may perfect your complaint if you do so within: the four-month filing period; or within 48 hours after the receipt of the notice, whichever is later.

Referral to Independent Review Organization: If your request is eligible for external review, the matter will be assigned to an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan has contracted with three IROs and rotates external review assignments among them. The IRO will be required to:

1. Timely notify you in writing concerning your request's eligibility and acceptance for external review, as well as information on submitting additional information.

2. Use legal experts, where appropriate, to make coverage determinations under the terms of the Plan.

3. Notify you of your right to submit additional information in writing for the IRO to consider in making its decision.

4. Notify the Plan of and provide to the Plan, within one day of receipt, any additional information you provide regarding your claim appeal. If the Plan reverses its denial and provides coverage or payment based on this additional information, then the external review can be terminated.

5. Timely review all information and documentation by the IRO. In reaching its decision, the IRO will review the claim de novo and not be bound by any prior decisions or conclusions reached during the Plan's internal claims appeal procedures. The IRO will consider the following in reaching a decision:

    a. your medical records;

    b. the attending health care professional's recommendation;

    c. reports from appropriate health care professionals and other documents submitted by the Plan, you, and your treating provider;

    d. the terms of the Plan to ensure that any decision reached is not contrary to the Plan's terms unless the terms are inconsistent with law;

    e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

    f. any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

    g. the opinion of the IRO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

6. Provide written notice of the IRO's final external review decision to you and the Plan within 45 days after the IRO received the initial request for the external review. The IRO's decision notice will contain:

    a. a general description of the reason for the request for external review, including the date(s) of service; the health care provider; the claim amount; the diagnosis and treatment codes and their corresponding meanings, upon request; and the reason for the previous denial;

    b. the date the IRO received the assignment to conduct the external review and the date of the IRO decision;

c. references to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision;

d. a discussion of the principal reason(s) for its decision, including rationale for its decision and any evidence-based standards that were relied on in making its decision;

e. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan;

f. a statement that judicial review may be available to you; and

g. current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

Maintaining Records: After the IRO reaches its final external review decision, the IRO will maintain all records of all claims and notices associated with the external review process for six years. The IRO must make all such records available for examination by you, the Plan, any state or federal oversight agency, upon request, except if such disclosure would violate state or federal privacy laws.

Reversal of Plan's Decision: The Plan, upon receipt of notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, immediately will provide coverage or payments for the claim.

Expedited External Review

Request for Expedited External Review: The Plan will allow you to make a request for an expedited external review at the time you receive:

1. An adverse benefit determination if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

2. A final internal adverse benefit determination if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or

3. A final internal adverse benefit determination if it concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency service, but you have not yet been discharged from a facility.

Preliminary Review: Immediately upon receipt of a request for an expedited external review, the Plan will determine whether the request meets the reviewability requirements and send written notice to you regarding whether you are eligible for an expedited external review.

Referral to Independent Review Organization: Upon determination that a request is eligible for external review, following the preliminary review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO as expeditiously as possible, including but not limited to e-mail, telephone, or fax.

Review of Documents: In reaching its decision, the IRO will consider your medical records and other documents to the extent appropriate.

Notice of Final External Review Decision: The IRO will provide notice of its final expedited external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

The decision of the IRO will be binding on the Plan as well as you, except to the extent other remedies are available under federal or state law. The Plan must provide benefits pursuant to the IRO decision without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner. You will be given maximum opportunity to present your viewpoint on any denied claim. You may not begin any legal action, including proceedings before administrative agencies, until you have followed the procedures and exhausted the internal and external appeal opportunities described here. However, if the Plan fails to adhere strictly to the requirements of the Regulations, you will be deemed to have exhausted the internal claims appeal procedures with respect to a claim and can seek external review or file a claim in court (unless the violation was de minimis, non-prejudicial, due to good cause or matters beyond the Plan's control, or in the context of an ongoing, good-faith exchange of information with you, and not reflective of a pattern or practice of non-compliance). You may, at your own expense, have legal representation at any stage of these review procedures. No legal action for any benefits under the Plan may begin later than two years after the time the claim was required to be received by the Fund Office as specified on page 85. Benefits under this Plan will be paid only if the Board of Trustees (or its Administrative Manager) decides in its discretion that you are entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including but not limited to, its Administrative Manager). Such decision will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan.

If you have any questions about the claims appeal procedures described here, please contact the Fund Office.

YOUR RESPONSIBILITIES AS A PARTICIPANT UNDER THE PLAN

1. NOTIFY THE FUND OFFICE IMMEDIATELY REGARDING ANY CHANGE IN ADDRESS OR DESIRED CHANGE IN BENEFICIARY.

Most information about your Plan is sent to you by mail. For you to receive this information, we must have a correct address on file at the Fund Office at all times.

If you move, it is up to you to let us know your new address. Failure to do so may jeopardize your eligibility or benefits because we will have no way to contact you about any changes in the Eligibility Rules or changes in benefits.

The responsibility for advising the Fund Office of your new address is yours, and you must do so in writing.

2. NOTIFY THE FUND OFFICE OF A CHANGE IN MARITAL STATUS.

If your marital status changes or there are other changes which might affect the name of the person(s) you wish to designate as your beneficiary, you must notify the Fund Office in writing regarding any change in beneficiary you wish to make.

Once each year the Fund Office will mail you a "Family Information Form." You are required to update this form on a yearly basis.

3. NOTIFY THE FUND OFFICE WHEN YOU OR YOUR DEPENDENT HAS A CHANGE IN GROUP HEALTH COVERAGE.

You must inform the Fund Office if you or one of your dependents has a change in coverage under another group health plan so this Plan can coordinate benefits properly.

4. MAKE SELF-PAYMENTS ON TIME AND IN THE CORRECT AMOUNTS.

Benefits paid by this Plan are financed primarily by employer contributions based on the number of hours worked. However, the Plan also provides that if you are not employed or have not worked the required minimum number of hours to maintain eligibility, you may make up the difference with self-payments.

You will be notified if self-payments are required to maintain your eligibility. The self-pay notice indicates the amount due and the date due. Failure to pay the required amount on time will lead to a loss of eligibility.

The responsibility for making timely self-payments is yours.

5. NOTIFY THE FUND OFFICE IF YOU ARE WORKING OUTSIDE OF THIS FUND'S JURISDICTION.

Because of the nature of the construction industry, you may work in several different locations under the jurisdiction of several different trust funds during the year. So that you will not lose benefits as you change employers, many trust funds have what is called a "reciprocity agreement."

Reciprocity means that when you work in the jurisdiction of another local (or Regional Council) and, therefore, in the jurisdiction of another fund, you may request that the contributions paid by your employers to the other fund be transferred to this Fund (your home fund) and that the hours be credited to your account for determining eligibility. Transferring hours earned in the jurisdiction of another fund may reduce or cancel a self-payment you otherwise would have to make to maintain eligibility.

A list of trust funds that currently have reciprocity agreements with this Fund is available at the Fund Office. Your Local Union or Regional Council or the Fund Office also can tell you if the trust fund where you are working has a reciprocity agreement with this Fund and can provide you with the forms necessary to request a transfer of hours. You also may access the transfer form online: www.ncscbf.com.

In the event you work in some other union's jurisdiction with which there presently is no reciprocity agreement, contact the Fund Office or your Union Office and efforts will be made to obtain a reciprocity agreement.

THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 (FMLA) requires covered employers to provide a certain amount of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for the same covered employer for at least 12 months, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles of that worksite.

Reasons for Taking Leave

Up to 12 weeks of unpaid leave must be granted for **any** of the following reasons:

1. to care for the employee's child after birth, or placement for adoption or foster care;

2. to care for the employee's spouse, son or daughter, or parent who has a serious health condition;

3. for a serious health condition that makes the employee unable to perform his job; or

4. because of “any qualifying exigency” arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. The Secretary of Labor will issue regulations defining “any qualifying exigency.”

An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious injury or sickness sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. This military caregiver leave is available during “a single 12-month period” during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

At the employee's or employer's option, certain kinds of **paid** leave may be substituted for unpaid leave.

Advance Notice and Medical Certification

The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable." An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work. Taking of leave may be denied if these requirements are not met.

Job Benefits and Protection

1. For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

2. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

3. The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

1. interfere with, restrain, or deny the exercise of any right provided under FMLA; or

2. discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.

An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under "U.S. Government, Department of Labor."

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

STATEMENT OF PARTICIPANTS' RIGHTS UNDER ERISA

The Employee Retirement Income Security Act, commonly referred to as ERISA, sets forth certain minimum standards for the design and operation of privately-sponsored health care plans. The law also spells out certain rights and protections to which you are entitled as a participant.

Trustees of the North Central States Regional Council of Carpenters' Health Fund want you to be fully aware of your rights, and for this reason, a statement of your rights follows.

As a participant in the North Central States Regional Council of Carpenters' Health Fund:

1. You automatically will receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

2. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.

   Federal regulations under HIPAA require that participants and beneficiaries receive a summary of material modifications of any modification or change that is a material reduction in covered services or benefits under a group health plan within 60 days after the adoption of the modification or change, unless the Plan sponsor regularly sends out summaries of the modifications or changes at regular intervals of 90 or fewer days.

3. Each year you automatically will receive a summary of the Plan's latest annual financial report. A copy of the full report also is available upon written request.

4. You may examine, without charge, all documents relating to this Plan. These documents include: the legal Plan Document, insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports (Form 5500 Series) and Plan descriptions.

   Such documents may be examined at the Fund Office (or at other required locations such as worksites or union halls) during normal business hours.

   In order to ensure that your request is handled promptly and that you are given the information you want, Trustees have adopted certain procedures which you should follow:

a. Your request should be in writing.

b. It should specify what materials you wish to look at.

c. It should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any worksite or union location at which 50 or more participants report to work. Allow 10 days for delivery.

5. You can obtain copies of any Plan document governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description upon written request to Trustees, addressed to the Fund Office. ERISA provides that Trustees may make a reasonable charge for the actual cost of reproducing any document you request. However, you are entitled to know what the charge will be in advance. Contact the Fund Office to determine what the charge will be.

6. You have the right to continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

7. You are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

8. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way or take any action which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

9. In accordance with Section 503 of ERISA and related regulations, Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim.

These procedures appear on pages 88 through 96 of this booklet. Basically, they provide that:

a. If your claim for a healthcare benefit is denied, in whole or in part, you have a right to know why this was done. You will receive a written explanation of the reason(s) for the denial, and you have a right to obtain copies of documents relating to the decision without charge.

b. Then, if you still are not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's claims appeal procedures.

These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented in your behalf.

10. In addition to creating rights for Plan participants, ERISA also defines the obligations of "fiduciaries," people involved in operating employee benefit plans. They have the duty to operate your Plan prudently and with reasonable care and to look out for your best interests as a participant under the Plan and the best interests of other Plan participants and beneficiaries under the Plan.

    The duties of a fiduciary are complex and are constantly changing as new laws and regulations applicable to employee benefit plans are adopted. Be assured that Trustees of this Plan will do their best to know what is required of them as fiduciaries and to take whatever actions are necessary to ensure full compliance with all state and federal laws.

11. Under ERISA, you may take certain actions to enforce the previously listed rights.

    a. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court.

        Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that: 1) the request was actually received; 2) the material was mailed to the right address; or 3) the failure to send the material was not due to circumstances beyond Trustees' control.

        If you are unable to get the information you want, you may wish to take legal action. The court may require Trustees to provide the materials promptly or pay you a fine of up to $110 for each day's delay until you actually receive the materials (unless the delay was caused by reasons beyond Trustees' control).

    b. Although Trustees will make every effort to settle any disputed claims with participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

        For this reason, you may file suit in a state or federal court if you feel you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

However, before exercising this right, you must take advantage of all the claims appeal procedures provided under the Plan at no cost. If you still are not satisfied, then you may wish to seek legal advice.

c. If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in federal court.

- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

- If you are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be expected to pay legal costs and fees.

We hope this booklet has provided you with the most important information about your Plan and your rights under ERISA.

If you have questions about your Plan, you should contact Trustees by writing to the Fund Office.

Or, if you have questions about this statement of your rights under ERISA or if you need assistance in obtaining documents from Trustees, you may contact the nearest office of the Employee Benefits Security Administration (EBSA) at U.S. Department of Labor listed in your telephone directory or at: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You also may find answers to your Plan questions, your rights and responsibilities under ERISA, and a list of EBSA field offices by contacting the EBSA by: calling 1-866-444-3272; sending electronic inquiries to www.askebsa.dol.gov; or visiting the website of the EBSA at www.dol.gov/ebsa/.

OTHER ERISA INFORMATION

PLAN NAME

The name of the Plan is the North Central States Regional Council of Carpenters' Health Fund.

THE NAME AND ADDRESS OF PLAN ADMINISTRATOR

The Plan is administered and maintained by the Board of Trustees. The Administrative Office of the Fund is located at:

THE BOARD OF TRUSTEES
North Central States Regional Council of Carpenters' Health Fund
1704 Devney Drive
Altoona, WI 54720
Mailing Address: P.O. Box 4002
Eau Claire, WI 54702

TYPE OF PLAN

The Plan is maintained for the exclusive benefit of the employees and provides Death and Weekly Accident and Sickness Benefits for employees and health care, vision, and dental benefits for employees and dependents. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PLAN SPONSOR

The Plan Sponsor is the Board of Trustees of the North Central States Regional Council of Carpenters' Health Fund. This Fund is maintained by several employers and one or more employee organizations, and is administered by a Joint Board of Trustees. A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries at the Fund Office.

PLAN ADMINISTRATION

Trustees hire and maintain an administrative staff under the direction and supervision of the Administrative Manager.

The Administrative Manager is responsible for carrying out Trustees' policy decisions, communications, recordkeeping, and accounting. Benefits are self-funded and Fund staff pays benefits subject to the Plan Document.

Any decisions of Trustees or the delegate of Trustees (including, but not limited to, the Administrative Manager) will be made in the sole and absolute discretion of Trustees or the delegate, as applicable, and will be final and binding upon all persons dealing with the Plan or claiming any benefit under the Plan, except to the extent the decision is determined to be arbitrary or capricious by a court having proper jurisdiction.

THE NAMES AND ADDRESSES OF TRUSTEES

Union Trustees

Greg Dhein
North Central States Regional
Council of Carpenters
N2216 Bodde Road
Kaukauna, WI 54130-9740

Robert Guenther
North Central States Regional
Council of Carpenters
N2216 Bodde Road
Kaukauna, WI 54130-9740

Chris Hill
North Central States Regional
Council of Carpenters
5238 Miller Trunk Highway
Hermantown, MN 55811

Burt Johnson
North Central States Regional
Council of Carpenters
700 Olive Street
St. Paul, MN 55130

Mark Kramer
North Central States Regional
Council of Carpenters
8805 Stettin Drive
Wausau, WI 54401

Wayne Nordin
North Central States Regional
Council of Carpenters
307 1st Street North
Virginia, MN 55792

John Raines
North Central States Regional
Council of Carpenters
700 Olive Street
St. Paul, MN 55130

Mert Summers, Jr.
North Central States Regional
Council of Carpenters
N2216 Bodde Road
Kaukauna, WI 54130-9740

Scott Watson
North Central States Regional
Council of Carpenters
5202 Monument Lane
Madison, WI 53704

Employer Trustees

Eric Ballweg
Vogel Brothers Building Company
P.O. Box 7696
Madison, WI 53707

David Bohl
AGC of Wisconsin
4814 East Broadway
Madison, WI 53716

Brad Deprez
IEI General Contractors
P.O. Box 5067
DePere, WI 54115-5067

F. William Harvat
N6506 County Road W
Waupaca, WI 54981

Jeff McLean
J.H. Findorff & Son, Inc.
300 South Bedford Street
Madison, WI 53703

Sid Samuels
The Samuels Group
311 Financial Way, #300
Wausau, WI 54401

Barry Scholz
The Boldt Company
2525 North Roemer Road
Appleton, WI 54912

Jerry Shea
Market & Johnson
P.O. Box 630
Eau Claire, WI 54702

Dave Smestad
C.R. Meyer Company
P.O. Box 2157
Oshkosh, WI 54903

PARTIES TO THE COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to collective bargaining agreements.

Participating Labor Organizations

North Central States Regional Council of Carpenters
Carpenters Industrial Council

Participating Employer Groups

Associated General Contractors of Wisconsin, Inc.

And those employers who are not members of or represented by such Association but which execute an individual collective bargaining agreement with the Local Unions.

The Union and Employer groups named here are parties to one of the several collective bargaining agreements requiring contributions be paid to this Trust Fund. A copy of any such agreement is available for examination by participants and their beneficiaries at the Fund Office during normal business hours. Also, upon written request to the Administrative Manager, participants and their beneficiaries may obtain:

1. a copy of any such agreement; and

2. information as to the address of a particular employer and whether that employer is required to pay contributions to the Plan.

INTERNAL REVENUE SERVICE EMPLOYER AND PLAN IDENTIFICATION NUMBERS

The Employer Identification Number (EIN) issued to the Board of Trustees is 39-6069788 and the Plan Number (PN) is 501.

NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR SERVICE OF LEGAL PROCESS IS:

Kristin Passineau, Administrative Manager
1704 Devney Drive
Altoona, WI 54720
Mailing Address: P.O. Box 4002, Eau Claire, WI 54702

Service of legal process also may be made upon any Plan Trustee.

ELIGIBILITY REQUIREMENTS

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules on pages 1 through 25. Circumstances which may cause the participant to lose eligibility are explained in the Eligibility Rules.

SOURCES OF TRUST FUND INCOME

Sources of Trust Fund income include employer contributions, self-payments, and investment earnings.

All employer contributions are paid to the Trust Fund subject to provisions in:

1. the collective bargaining agreements between the Unions and Associations;

2. those employers who are not members of or represented by such Associations but which execute an individual collective bargaining agreement with the Local Unions; and

3. employers signatory to such labor contracts who cover their non-bargaining unit employees (NBU) under Trustees' NBU Participation Agreement or Alumni Participation Agreement. For bargaining unit employees, labor agreements specify the amount of contribution, due date of employer contributions, type of work for which contributions are payable, and the geographic area covered by the labor contract. For non-bargaining unit employees, Trustees determine the employer contribution amount, due date, and related policies.

METHOD OF FUNDING BENEFITS

All benefits except organ transplant insurance are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets are allocated for reserves to carry out the objectives of the Plan.

Associated Bank, Green Bay, Wisconsin, is the custodian of Fund assets. Monies not needed for immediate payment of benefits are invested by Baird Advisors, Robeco, and Dearborn Partners in accordance with guidelines established and monitored by Trustees.

Benefits for certain organ transplants as described on pages 33 through 36 are provided through an insurance policy with National Union Fire Insurance Company of Pittsburgh, PA, c/o Medical Excess, 8777 Purdue Road, Suite 330, Indianapolis, IN 46268, 1-888-449-2377. Benefits eligible under the organ transplant insurance policy are submitted to and paid by National Union Fire Insurance Company of Pittsburgh, PA.

PLAN YEAR AND FISCAL YEAR

The Plan year and the fiscal year both begin January 1 and end the following December 31.

PROCEDURES TO BE FOLLOWED IN PRESENTING CLAIMS FOR BENEFITS UNDER THE PLAN

The procedures for filing for benefits are described on pages 85 through 87.

If a participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are found on pages 88 through 96.

PLAN AMENDMENT AND TERMINATION

The Board of Trustees expects that the Plan will be permanent. However, the Trustees have the right and the authority, in their sole discretion, to change, modify, eliminate benefits, or terminate all or any part of the Plan whenever, in their sole discretion, conditions so warrant. If all or a part of the Plan is terminated, the Trustees would provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plan, and distribute the balance of the assets in a manner consistent with the purpose of the Fund.

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