EASTERN ATLANTIC STATES
CARPENTERS BENEFIT FUNDS

HEALTH FUND

RETIRED

Summary Plan Description

January 2024

EASTERN ATLANTIC STATES CARPENTERS HEALTH FUND

SUMMARY PLAN DESCRIPTION RETIREE

EFFECTIVE: JANUARY 1, 2024

Introduction

The Eastern Atlantic States Carpenters Health Fund, ("**EASC Health Fund**") was formed by merger of the Northeast Carpenters Health Fund (the "Northeast Fund") and the Carpenters Health and Welfare Plan of Philadelphia and Vicinity (the "Philadelphia Fund"), effective December 31, 2022. The EASC Fund is maintained pursuant to various collective bargaining agreements ("CBAs") between the Eastern Atlantic States Regional Council of Carpenters (the "**Union**") or affiliated Local Unions and employers and/or employer associations covering New Jersey, Pennsylvania, Delaware and Maryland.

The EASC Health Fund offers a plan of benefits to those individuals who lose coverage through the EASC Health Fund's plan of benefits for Active Employees (hereinafter "Active Plan") because they have retired from work in Covered Employment, provided they meet certain eligibility provisions described herein. This plan is referred to herein as the "Retiree Plan" or the "Plan" and those individuals who meet the required eligibility provisions are referred to as "Retirees."

This booklet is your Summary Plan Description and Plan Document for the Retiree Plan offered by the EASC Health Fund effective January 1, 2023.

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

Retiree Health Plan Coverage

Eligibility

You are eligible for coverage through this Retiree Plan if:

- You are an Active Covered Participant in the EASC Active Plan both at the time of your retirement and the Benefit Period immediately preceding the Benefit Period in which you retire;
- You are currently receiving a pension through the Eastern Atlantic States Carpenters Pension Fund; and
- You have the required amount of Active Health Plan Credits, as described in detail below.

You are also eligible for coverage through this Retiree Plan if you were enrolled in or eligible to enroll in retiree coverage through the Northeast Fund or Philadelphia Fund prior to the merger of those funds effective at 11:59 p.m. on December 31, 2022.

Active Health Plan Credits

Retired health coverage is based on a credit system. Credits are based on your prior eligibility for Active Participant coverage in this Plan, the Northeast Carpenters Active Health Plan ("Northeast Active Plan"), or the Carpenters Health & Welfare Fund of Philadelphia and Vicinity Active Plan ("Philadelphia Active Health Plan"). Throughout your employment, you are granted a maximum of one (1) Active Health Plan Credit towards Retiree Plan coverage per Benefit Year.

Active Health Plan Credits are granted as follows:

- For each 6-month Gold Coverage, Philadelphia Active Health Plan eligibility period,** or Level II eligibility period in the Northeast Active Plan, you are granted 0.5 Active Health Plan Credits;
- For each 6-month Silver Coverage or Level I eligibility period in the Northeast Active Plan, you are granted 0.25 Active Health Plan Credits;
- For each missed eligibility period (i.e. each eligibility period you did not qualify for coverage, including any Benefit Periods in which you purchased COBRA), you are granted 0 Active Health Plan Credits.

****For Participants previously covered under the Philadelphia Active Health Plan,** prior Benefit Periods earned through "Vesting" or "Basic" Benefit Periods are not considered eligibility periods and you will not be entitled to Active Health Plan Credits for those periods.

Active Health Plan Credit Requirement

For Retirees previously covered under the Philadelphia Active Plan:

Retirees who were participants in the Philadelphia Active Plan must have earned 25 Active Health Plan Credits at the time of their initial retirement to be eligible for Retiree Plan coverage; however, these retirees will be required to pay a higher premium toward their coverage if they earned between 25 and 29 credits as opposed to 30 credits.

For Retirees previously covered under the Northeast Carpenters Active Health Plan:

If your first hour of work in employment requiring contributions to the Northeast Carpenters Active Health Plan or this Plan ("Hour of Service") was before April 1, 2011, you will need 25 Active Health Plan Credits to qualify for Coverage when you retire.

If your first Hour of Service was after April 1, 2011, you will need 30 Active Health Plan Credits to qualify for Coverage when you retire.

Retirees previously covered under the Northeast Carpenters Active Plan who retire on or after January 1, 2023 must have earned the required number of Active Health Plan Credits described above by the time of their initial retirement. Retirees who retired before January 1, 2023 but continued or returned to work in covered employment must have earned the required number of Active Health Plan Credits by the time they cease working in covered employment.

Payment Requirement

Retirees are responsible for paying a monthly premium toward the cost of their coverage. The required premium is set by the Trustees and will vary based on whether you are Medicare-eligible as well as whether you elect self-only coverage or coverage for you and your Eligible Family Members. You may not elect to cover your eligible family members without also electing to cover yourself. You will receive notice of the required premium when you initially begin Retiree coverage and, thereafter, when the Trustees make any change to the required premium. The monthly premium is due on or before the 1st of each month. Retirees must pay the required monthly premium amounts by authorized deduction from your monthly pension unless your gross pension amount is less than the monthly premium. Retirees who return to work and earn active coverage will not be required to pay a monthly premium until they resume retiree coverage following the loss of their active coverage.

If you are a Retiree previously covered under the Northeast Carpenters Active or Retired Health Plan and are Medicare-eligible, you may also purchase dental and vision benefits at a higher premium. For Retirees previously covered under the Philadelphia Fund who are Medicare-eligible, dental and vision are included in your monthly premium.

You and your Eligible Family Members can opt out of Retiree Plan coverage at retirement. However, you and your Eligible Family Members will only be able to enroll in Retiree Plan at a later date if you or your Eligible Family Member had continuous coverage under another group health plan since you lost coverage through the Active Plan.

You should also be aware that the Fund's retiree health coverage may be considered to be employer-provided health coverage for purposes of federal health insurance subsidies even if you are not actually receiving Retiree Plan benefits.

Your Eligible Family Members

If you are eligible for benefits under this Retiree Plan, your eligible family members are also covered for the same benefits as you, with limitations. Eligible family members include:

- The spouse to whom you are legally married, subject to the Working Spouse rule set forth in this SPD;
- Your children (your natural child, stepchild, legally adopted child, or child placed with you for adoption) who are not yet age 26;
- Your children (your natural child, stepchild or legally adopted child) who are at least age 26 and who are eligible for Social Security Disability or can be claimed on your tax return as an eligible dependent; and
- A child covered by a Qualified Medical Child Support Order.

In order for the Retiree Plan to enroll your eligible family member in coverage, he or she must have a social security number or taxpayer identification number. Please refer to the Special Enrollment Section of this SPD for instructions on what to do if you have a new Eligible Family Member (e.g. you get married or have a child). If you pass away while you have a level of coverage in this Plan, your eligible family members are entitled to continue coverage until the end of the month that is 12 months from the date of your death. Thereafter, your spouse will be offered "Surviving

Spouse" coverage and your eligible family members will be offered COBRA continuation coverage.

Working Spouse Rule

Your spouse is required to enroll in any group health plan offering medical benefits made available to him or her by their employment. This requirement shall not apply to any spouse who does not work, is self-employed, or who is required by his or her employer to pay more than the Affordable Care Act's Affordability Threshold for the cost of coverage. Any spouse who is eligible for employer-sponsored medical coverage but fails to enroll during an applicable open-enrollment period must enroll at the next available opportunity. Any spouse who fails to enroll in available coverage as of the next available opportunity whether that opportunity is special enrollment or open enrollment, will receive secondary coverage after the date of that opportunity. All spouses will be required to complete a verification form each year that confirms he or she meets one of the conditions above for exemption unless copies of the other insurance carrier ID cards are already on file.

Working Retiree Rule

If you are eligible to enroll in a group health plan provided through your non-disqualifying employment, you are required to enroll in that coverage and this Plan will provide secondary coverage. This requirement shall not apply if you are required by your employer to pay more than the Affordable Care Act's Affordability Threshold for the cost of coverage. You are required to notify the Plan if you become eligible for employer sponsored coverage while enrolled in retiree coverage through this Plan. If you fail to do so, the Trustees may terminate your coverage and seek recovery of any and all claims paid on your behalf.

Coverage for Eligible Children

Benefit coverage for children will generally stop as of the first of the month following the date on which they turn age 26, except that if your child is permanently disabled and the disability occurred prior to your child attaining age 26, he/she may continue to be covered under the Plan as long as he/she remains totally and permanently disabled. The Plan must be provided with supporting documentation of the disability from the Social Security Administration or proof of tax-eligibility status prior to the date on which your child would otherwise lose eligibility. You must also complete a Disabled Child Questionnaire provided by the Fund Office and any other documentation deemed necessary by the Board of Trustees on an annual basis.

Qualified Medical Child Support Order (QMCSO)

The Plan will pay benefits in compliance with a court-issued Qualified Medical Child Support Order (QMCSO) that meets Plan and applicable ERISA standards. The Plan will treat a medical support order as a claim for benefits under the Plan and issue a letter acknowledging that the order is "qualified" (so as to entitle the child to benefits) or that it is "not qualified" and will not be accepted by the Plan. Any party to the order can appeal the Plan's determination under the procedures for appeal of a benefit denial.

Annual Enrollment/COB Form Required

Pre-Medicare Participants must complete an Annual Enrollment/COB Form for all eligible family members once per Benefit Year.

Mandatory Medicare Enrollment Requirement

Any Retiree or Eligible Family member who is eligible for Medicare **must** enroll in Medicare Parts A and B if they are eligible. The Retiree Plan will only provide coverage that is secondary to Medicare to any Retiree or Eligible Family member who is eligible but fails to enroll in Medicare Parts A and B.

When Coverage Ends

If you are a Retiree, your coverage under the Retiree Plan ends when:

- You pass away;
- You become eligible for coverage through the EASC Active Plan;
- Your pension is suspended for reasons other than employment for a Contributing Employer; or
- You fail to pay the required premium for coverage.

A Retiree's Eligible Family Member's coverage ends:

- When the Retiree's coverage ends, except in the event of death as described below;
- When they pass away;
- For an Eligible Family Member that is a spouse, at the end of the month in which he or she becomes divorced from the Retiree;
- For an Eligible Family Member that is a child, at the end of the month in which he or she no longer qualifies as an eligible family member (i.e. he or she attains age 26 or, if older, is no longer determined to be disabled).

If a Retiree dies, his or her covered spouse and eligible family members will receive continued coverage for 12

months from the date of death at the same premium rate applicable to their coverage prior to the Retiree's death. Thereafter, the spouse will be considered a "Surviving Spouse" and required to pay the applicable premium (set at the same rate as the COBRA rate for the Benefit Year) for continued Retiree coverage. Eligible family members will be offered thirty-six (36) months of COBRA coverage following a Retiree's death.

Following a Retiree's death, a spouse's coverage will end if he/she fails to pay the required premium.

Newborns and Mothers Health Protection Act of 1996

The Retiree Plan 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. However, the law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). In any case, the Retiree Plan may not, under federal law, require that a provider obtain authorization from the Plan or the insurer for prescribing a length of stay less than 48 or 96 hours.

Women's Health and Cancer Rights Act of 1998

The Retiree Plan covers the following medical services in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications in all stages of mastectomy, including lymph edemas.

The Retiree Plan covers these services for eligible women in a manner determined in consultation with the attending physician and the patient through Independence Administrators. There are no deductibles, co-payment, or co-insurance limitations applicable to this coverage provided you obtain these services/drugs from a network provider or pharmacy.

Preventive Care

The Affordable Care Act (ACA) requires the Retiree Plan provide Pre-Medicare Participants coverage of certain services and prescription drugs at 100%. For any services or prescription drugs that meet the ACA's definition of "Preventive Care" Pre-Medicare Retirees will not be responsible for any deductible or coinsurance provided they obtain these services/drugs from a network provider or pharmacy.

Health Benefits

The Health Benefits for which you and your Eligible Family members are eligible depend on whether you or your Eligible Family member is eligible for Medicare.

Any Retiree or Eligible Family Member who is not yet Medicare-eligible is referred to herein as a "Pre-Medicare Participant" and will receive the benefits described below for Pre-Medicare Participants.

Any Retiree or Eligible Family member who is Medicare-eligible is referred to herein as a "Medicare-eligible Participant" and will receive the benefits described below for Medicare-eligible Participants.

The list of the benefits for which you are eligible at each level of coverage are set forth in the chart herein. If you are a COBRA enrollee, you are eligible for the same health benefits as similarly situated retirees and their eligible family members.

Health Benefit Coverage	
If you are a……	**Your Coverage will be…**
Pre-Medicare Participant	• BlueCard PPO 90/10 medical coverage; • ESI prescription drug coverage; • Mental Health Consultants behavioral health and substance use disorder benefits 90/10 coverage; • Cigna Dental benefits; • Davis Vision benefits; and • Fund Administered Benefits
Medicare-Eligible Participant	• Blue Advantage • ESI EGWP prescription drug coverage; and • the Hearing Aid Discount Benefit plus • Cigna Dental benefits; and • Davis Vision benefits (former Philadelphia Plan participants or if elected by former Northeast plan participants)

Important Terms

For purposes of all of the Plan's benefits, you should familiarize yourself with the below terms and their meanings:

COINSURANCE is your share of the costs of eligible medical expenses covered by the Plan. For example, with the Plan's 90/10 coinsurance plan, the Plan pays 90% of covered eligible medical expense charges and you pay 10%.

A COPAY is a fixed amount you pay for a covered health care service after you've satisfied any applicable deductible.

A DEDUCTIBLE is the amount you are required to pay before the Plan begins to pay for eligible medical expenses covered by the Plan.

OUT-OF-POCKET MAXIMUM is the maximum amount you are required to pay out-of-pocket in a Benefit Year for eligible medical expenses covered by the Plan. Once you hit your out-of-pocket maximum, the Plan will pay 100% of the eligible medical expenses covered by the Plan for the remainder of the Benefit Year. In other words, your coinsurance is 0% for eligible medical expenses covered by the Plan once you satisfy the Plan's out-of-pocket maximum.

This Plan maintains an out-of-pocket maximum separately for medical benefits through IA and MHC (i.e. Blue Card PPO coverage), prescription drug benefits through ESI, and the Ambulance Benefit through the Fund. The combined out-of-pocket maximum will not exceed the maximum limit required by federal law.

Network Providers

Network providers are providers who will accept the Plan's and the Plan's Vendor's allowances as payment-in-full for their services. These providers are called "network providers" or "preferred providers" because they have contracted with the Fund and/or its vendors for a negotiated fee for their services, and will not balance-bill you above your specified coinsurance after the services are performed. The Plan will provide a separate listing of these network providers upon your request at no charge. For medical benefits through Independence Administrators a list of network providers is available at https://www.ibxtpa.com/login. For behavioral health and substance use disorder benefits through Mental Health Consultants, you can view a listing of Network Providers on the internet at http://www.mhconsultants.com/. For dental benefit providers through Cigna, visit www.mycigna.com and for vision benefit providers through Davis Vision visit www.davisvision.com.

Payment of a claim by the Plan will normally be made to the Network Provider. When you utilize a Network Provider, payment of a claim will be made to you only when you or your health care provider submits a paid receipt to the Fund or Vendor for covered services. You may refer to the booklets at the end of this section for detailed information regarding your total health care coverage.

Pre-Medicare Participant Health Benefits

Please note that throughout this Health Benefits Section of this SPD, "you" refers to Pre-Medicare Participants.

Out-of-Pocket Maximums

Out-of-Pocket Limits			
Gold Coverage			
		In-Network	**Out-of-Network**
Independence Administrators ("IA")/Mental Health Consultants ("MHC") Benefits	Individual	$1,000	$25,000
	Family	$2,000	$50,000
Prescription Drugs	Individual	$6,000	n/a
	Family	$12,000	n/a
Ambulance	Individual	$1,000	n/a
	Family	$2,000	n/a

Deductible

Pre-Medicare Participant medical coverage is "Gold Coverage" which has no deductible for In-network coverage and a $10,000 deductible for out-of-network coverage.

Medical Benefits

Blue Card PPO

Pre-Medicare Participants' medical coverage is administered by Independence Administrators who processes claims and handles administrative services for the medical, surgical, hospitalization and certain other Plan benefits. The benefits are not insured, as the Plan pays Independence Administrators for the cost of all benefits paid on a weekly basis. You should use your Independence Administrators card for these benefits. The BlueCare PPO benefit booklet is available online and contains specific details regarding the Plan's medical benefits including, but not limited to inpatient hospital services, outpatient services, and medical/surgical covered services.

You may contact Independence Administrators directly, if necessary, at (833) 242-3330.

You can also go to the Independence Administrators website at: https:/www.myibxtpabenefits.com

Mental Health and Substance Use Disorder Benefits

If you need to obtain care for a mental health condition, treatment for substance use disorder or family services (including individual and group counseling, psychotherapy and tutorial services), you should call Mental Health Consultants ("MHC") at 1-800-255-3081 or 215-343-8987 or the Fund Office for assistance. MHC is located at 1501 Lower State Road, Building D, Suite 200, North Wales, PA 19454.

MHC can assist you in choosing a participating provider. Please contact the Fund Office by written request or MHC at 1-800-255-3081 or 215-343-8987 for a listing of participating providers and programs that are available. These benefits are not insured and are paid solely with Plan assets.

If your benefits are denied by MHC, you can appeal under the applicable procedures in the Claims section of this booklet.

Cost-Sharing Provisions for Medical and Mental Health and Substance Use Disorder Benefits

Gold Coverage is a 90/10 Plan which generally means that the Plan pays 90% of covered eligible medical expenses and you pay 10%. For the benefit year beginning January 1, 2023, Gold Coverage has an out-of-pocket maximum of $1,000 per individual/$2,000 per family.

For more details regarding what are considered covered eligible medical expenses and what counts toward the out-of-pocket maximums, please refer to the BlueCard PPO booklet on the Fund's website.

Out-of-Network

If you choose to use a provider that is not a network provider, you may have additional costs, depending on your level of coverage.

For Gold Coverage, the out-of-network coinsurance for Medical/Behavioral Health is 50/50, which generally means that the Plan pays 50% of the Allowable Rate (120% of Medicare Allowance) for covered eligible medical expenses, and you pay 50%. Gold Coverage has a $10,000 out-of-network deductible and a $25,000 out-of-pocket maximum.

Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. Generally, "balance billing" is when you receive services from a provider or facility and owe certain out-of-pocket costs for the difference between what the Plan agrees to pay and the full amount charged for the service if the provider or facility does not participate with the Plan.

You are protected from balance billing for:

- Emergency services; and
- Certain services at an in-network hospital or ambulatory surgical center.

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such as deductibles, copayments, and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance

bill you and may **not** ask you to give up your protections from balance billing.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are <u>never</u> required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in the Plan's network.

When balance billing is prohibited, you are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). The Plan will pay any additional costs to out-of-network providers and facilities directly. Additionally, the Plan generally must:

- Cover emergency services without requiring you to get approval for services in advance;
- Cover emergency services by out-of-network providers;
- Base what you owe the provider or facility on what it would pay an in-network provider or facility and show that amount in your explanation of benefits; and
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you have been wrongly billed, contact the No Surprise Help Desk at 1-800-985-3059.

Quest and LabCorp

If you obtain covered laboratory services (e.g. bloodwork) through Quest Diagnostics or LabCorp, you will not be subject to the coinsurance that otherwise applies to medical claims.

MDAnderson Cancer Center at Cooper

The Plan has a partnership with MD Anderson Cancer Center at Cooper to offer you a waiver of coinsurance if you go to any MD Anderson at Cooper locations for cancer treatment and follow ups. For more information, you should call (856) 735-6210, the Plan's dedicated phone number and provide your IA Card information.

Ivy Rehab

Participants and their eligible family members who obtain physical therapy through an Ivy Rehab location will not be subject to the coinsurance that otherwise applies for physical therapy services.

Telehealth

You have access to a doctor, including a mental health provider, therapist, dermatologist, etc., via video or phone through Teladoc. Teladoc can be used when:

- You need to see a doctor, but can't fit it into your schedule.
- Your doctor's office is closed.
- You feel too sick to leave the house.
- You need care for your children.
- You're traveling and forgot a prescription or need a doctor.

Teladoc is available at $0 cost to Active Covered Participants and their Eligible family members. To useTelado participants Teladoc online at teladochealth.com, or contact Teladoc by phone at (800) 835-2632. For more information on accessing Teladoc, please refer to the Fund's website.

Fund Administered Medical Benefits

The below medical benefits are administered by the Fund Office.

Ambulance Reimbursement

You are eligible for reimbursement of up to $1,000 per trip for emergency ground ambulance services including both the Ambulance and the Paramedics. You will pay out-of-pocket for any expenses for ground ambulance services in excess of $1,000 per trip, subject to an out-of-pocket maximum of $1,000 per Benefit Year.

Temple Heart and Lung Scans

The Plan has an arrangement with Temple Center for Population Health (Temple) to provide a Heart and/or Lung Scan to you. You are eligible for one or both Scan(s) once every three (3) years, or more frequently with a medical professionals letter of medical necessity. Eligibility is based on age and gender according to the American Medical Association's guidelines for these Screenings: for men eligibility begins at age 40, for women eligibility begins at age 50; for both, eligibility can begin earlier with a medical professionals letter of medical necessity. To obtain a Scan, call the Temple Access Center at 215-707-8800. More information on this benefit is available on the Plan's website at:

https://carpenters.fund. Claims for Temple Health/Lung Scans are paid by the Fund Office.

In-House Physicals/Catapult Health Check Up

The Plan has an arrangement with Patient First and Robert Wood Johnson to provide you In-House Physical Examinations. The Health Fund will pay for one (1) physical examination for a Pre-Medicare Participant age 16 or over once per year at either location.

The Plan has a partnership with Catapult to provide you with onsite and/or virtual (at home) preventive health checkups, including: (1) blood tests with prompt results; (2) height, weight, abdominal circumference and blood pressure measurements; (3) a tailored personal health report that provides a summary of findings with specific recommendations for lowering risk factors and improving health; and (4) health reports reviewed with a Nurse Practitioner (via video/audio conference) who addresses the risk factors identified, if any, and recommends a personal action plan. More information on this benefit is available on the Plan's website at https://carpenters.fund.

Upon completion of a In-House Physical or a Catapult Health Check Up, the Fund Office will issue a $25 Gift Card to any Participant or Spouse (eligible children are not eligible to receive a Gift Card) . Only one Gift Card per eligible individual will be available per Plan Year. More information on this benefit is available on the Plan's website at: https://carpenters.fund. Claims for Comprehensive Physical Examinations are paid by the Fund Office.

Virta

The Plan has an arrangement with Virta to provide you with tools, supplies, and support associated with managing the following diseases: Prediabetes, Diabetes, and Obesity. Eligibility is determined based on disease specific criteria as determined by Virta Health. More information on this benefit is available on the Plan's website at: https://carpenters.fund or the Virta website at: www.virtahealth/join/eas. Claims for Virta are paid by the Fund Office.

ColoFit

The Plan has an arrangement with ColoFit to provide you with an at-home colorectal cancer screening kit. More information on this benefit is available on the Plan's website at: https://carpenters.fund, on the ColoFit website at: www.coloncancerscreenitkit/eas , or by calling 1-888-996-0650. You are entitled to one screening kit per year. Claims for Colofit are paid by the Fund Office.

HCSC C-Pap

The Plan has an arrangement with Health Care Solutions Corp. (HCSC) to provide you with maintenance C-PAP/BI-PAP supplies, and support associated with managing sleep apnea at no cost to you. Additionally, C-Pap/BI-Pap Machines can be purchased through HCSC at a discounted rate with the applicable cost share for your level of coverage. More information on this benefit is available on the Plan's website at: https://carpenters.fund. You may also contact HCSC at (800) 655-8125 or online at: www.hcsolutionscorp.com.

Hearing Aid Discount Benefit

The Plan has a partnership with Audionet America/Birdsong to provide you with Hearing Aids. You will receive an allowance of $600 per ear every two (2) years to be used to purchase Hearing Aids.

Prescription Drug Benefits – Pre-Medicare Participants

The Plan offers you prescription drug benefits which are not insured and are paid solely by Plan assets. Express Scripts, Inc. (ESI) located at 1 Express Way, St. Louis, MO 63121, phone number 800-939-2146, administers Prescription Benefits. ESI maintains the participating pharmacy provider network and card services, processes claims and handles administrative services for prescription drug coverage.

Contact ESI Member Services at 1-800-939-2146 for a list of participating independent, chain and other or visit ESI's website at www.express-scripts.com.

The Plan covers legend drugs only; no over-the-counter drugs are covered except as otherwise provided in ESI's formulary.

ESI's formulary is available on the Fund's website at: www.members.carpenters.fund/benefit-coverageprescriptions-pharmacies.

If you have trouble accessing the formulary and need a paper copy, please contact the Fund Office at (732) 417-3900. Questions regarding whether a specific drug is covered should be directed to ESI at the Member Service's number above. To receive prescription drugs

at a discount off the average wholesale price, please use any network pharmacy.

See the chart below for the Plan's cost sharing structure for all prescriptions.

Cost Sharing for Participating Pharmacies

	Retail 30-Day Supply	Mail Order or CVS Walk-In 90-Day Supply
Generic	$5.00	$10.00
Preferred Brand	25% coinsurance, subject to maximum of $75	25% coinsurance, subject to a maximum of $150
Non-Preferred Brand	40% coinsurance	40% coinsurance

Lists of which drugs are considered preferred brand can be obtained on ESI's website at www.express-scripts.com.

The Prescription Plan excludes a few drugs from coverage, as follows: in the broad level classification, non-legend drugs classified as over-the-counter, and drug efficacy study indicator drugs, determined by the FDA as lacking substantial evidence of effectiveness, are not covered. Also, drug specifics, including blood and blood plasma, immunization agents, cosmetic medications including Retin-A and minoxidil ("Rogaine"), over-the-counter smoking deterrents such as Nicorette or Nicoderm, and non-legend vitamins, are not covered. Generally, there are quantity, gender and other limitations on prescriptions.

Mandatory Mail-Order Prescription Service for Maintenance Drugs

If you use a maintenance medication, you must use the mail-order prescription drug service through ESI by Mail or a CVS Retail location. If you try to fill a prescription at a retail pharmacy other than a CVS Pharmacy after your third fill, you will be responsible for 100% of the cost of the prescription. You can call ESI's Mail Order Pharmacy at (800) 987-7838, or you can visit ESI's website www.express-scripts.com.

Mandatory Process for Specialty Drugs

Specialty Medications are typically injectable medications administered either by you or a health care professional, and often require special handling. They must be pre-approved by Accredo specialty pharmacy and will be administered by ESI. Your provider must obtain preapproval from Accredo at (800) 803-2523.

Health Insurance Solutions, Inc. ("HISI")

The Plan has a partnership with Health Insurance Solutions, Inc., ("HISI") to assist you in getting financial assistance for certain Specialty Medications. If you are prescribed and pre-approved for a Specialty Medication, the Fund Office and/or HISI may reach out to you to discuss whether financial assistance is available.

Medicare-Eligible Participant Medical Benefits

Please note that throughout this section of this SPD, "you" refers to Medicare-eligible Participants.

Blue Advantage Medical Benefits

Medicare Eligible Participants are eligible for Blue Medicare Advantage which includes a Medicare Advantage Plan and a Medicare Part D Prescription Plan. A summary of these benefits is attached hereto as **Appendix A** and is available for download on the Fund's Website at this link:

https://members.carpenters.fund/benefit-coverage/blue-medicare-advantage/

For more information on Blue Medicare Advantage, you should visit their website at

www.bluemedadvgrhs.com

or you can call member services at (844) 430-0326.

Hearing Aid Discount Benefit

Medicare-eligible Participants are eligible for the Hearing Aid Discount Benefit administered by the Fund Office. The Plan has a partnership with Audionet America/Birdsong to provide you with Hearing Aids. You will receive an allowance of $600 per ear every two (2) years to be used to purchase Hearing Aids.

Prescription Drug Benefits – Medicare-Eligible Participants

Please note that throughout this Health Benefits Section of this SPD, "you" refers to Medicare-eligible Participants.

The Plan offers you prescription drug benefits through Express Scripts Medicare Employer Group Waiver Plan ("EGWP") which are not insured and are paid solely by Plan assets. Express Scripts, Inc. (ESI) located at 1 Express Way, St. Louis, MO 63121, phone number 800-939-2146, administers EGWP Prescription Benefits. ESI maintains the participating pharmacy provider network and card services, processes claims and handles administrative services for prescription drug coverage.

Contact ESI Member Services at 1-800-939-2146 for a list of participating independent, chain and other or visit ESI's website at www.express-scripts.com.

The Plan covers legend drugs only; no over-the-counter drugs are covered except as otherwise provided in ESI's formulary. ESI's EGWP formulary is available on the Fund's website at www.carpenters.fund If you have trouble accessing the formulary and need a paper copy, please contact the Fund Office at (732) 417-3900. Questions regarding whether a specific drug is covered should be directed to ESI at the Member Service's number above. To receive prescription drugs at a discount off the average wholesale price, please use any network pharmacy.

See the chart below for the Plan's cost sharing structure for all prescriptions.

Cost Sharing for Participating Pharmacies		
	Retail 30-Day Supply	**Mail Order or Retail 90-Day Supply**
Generic	$5.00	$10.00
Preferred Brand	25% coinsurance, subject to maximum of $75	25% coinsurance, subject to a maximum of $150
Non-Preferred Brand	40% coinsurance	40% coinsurance
Specialty	25% Coinsurance	25% Coinsurance

Lists of which drugs are considered preferred brand can be obtained on ESI's website at www.express-scripts.com.

The Prescription Plan excludes a few drugs from coverage, as follows: in the broad level classification, non-legend drugs classified as over-the-counter, and drug efficacy study indicator drugs, determined by the FDA as lacking substantial evidence of effectiveness, are not covered. Also, drug specifics, including blood and blood plasma, immunization agents, cosmetic medications including Retin-A and minoxidil ("Rogaine"), over-the-counter smoking deterrents such as Nicorette or Nicoderm, and non-legend vitamins, are not covered. Generally, there are quantity, gender and other limitations on prescriptions for lifestyle drugs, such as drugs for erectile dysfunction where a limit of 6 pills per month is allowed.

Mail-Order Prescription Service for Maintenance Drugs

If you use a maintenance medication, you may, but are not required to, use the mail-order prescription drug service through ESI. If you would prefer to get your medications via Mail Order, you must use ESI's Mail Order Pharmacy at (800) 987-7838, or you can visit ESI's website www.express-scripts.com.

Mandatory Process for Specialty Drugs

Specialty Medications are typically injectable medications administered either by you or a health care professional, and often require special handling. They must be pre-approved by Accredo specialty pharmacy and will be administered by ESI. Your provider must obtain preapproval from Accredo at (800) 803-2523.

Dental and Vision Benefits – All Retirees

Eligibility for Dental and Vision Benefits

The Plan offers dental and vision benefits to you and your eligible family members.

Pre-Medicare Eligible Participants as well as former Philadelphia Fund Participants who are Medicare-eligible are eligible for Dental and Vision Benefits as part of their monthly premium.

Medicare-eligible Participants previously covered under the Northeast Carpenters Active or Retired Health Plan are eligible for Dental and Vision coverage but will be required to pay an additional premium for these benefits. You will have the option to elect Dental and Vision benefits when you first become Medicare-Eligible and will be notified of the required premium as part of that election and, if elected, when there is any

change to the required premium for this coverage. If you do not elect Dental and Vision Benefits when you first become Medicare-eligible or, if later, when you first enroll in coverage through this Retiree Plan, you will not be eligible to elect these benefits in the future.

Dental Benefits

These benefits are not insured and are paid solely by the Plan. Cigna dental administers these benefits.

The Plan's dental benefits are a 90/10 coinsurance plan with a maximum benefit of $2,500 per family per Benefit Year. Preventive and diagnostic care is paid at 100% but counts against the overall Family Allowance. Additionally, up to $3,200 per individual per lifetime is allowed for orthodontia, separate from the Maximum Family Allowance. For more details on the Plan's dental benefits, refer to the dental benefits section of the Fund's website or contact CIGNA at (800) CIGNA24.

Vision Benefits

These benefits are not insured and are paid solely by the Plan. Davis Vision administers the Plan's vision benefits.

The Plan's vision benefits cover eye exams at 100% for In-Network Providers and offers an allowance of $100 for frames and lenses or contact per participant per Benefit Year. An additional $50 is allowed if frames and/or lenses (contacts are not eligible for the additional $50) are obtained at Visionworks. For more details on the Plan's vision benefits, refer to the vision benefits booklet on the Fund's website at: https://carpenters.fund or contact Davis Vision at: (800) 999-5431.

Health Reimbursement Account Benefit

Retirees who have a balance remaining in their HRA account for contributions paid to the fund on their behalf while they were an active employee will be able to use any balance remaining in their HRA account for their eligible out-of-pocket medical expenses.

The Plan provides HRA Eligible Retirees with a MasterCard which you can use for eligible medical expenses in lieu of cash. If it is not possible for you to use the MasterCard for an eligible medical expense, you may submit claims through the participant web portal which can be accessed through the Fund's website at https://carpenters.fund. If you are unable to obtain reimbursement through the portal, you may submit a claim form to the Fund Office by mail.

To be reimbursed from the HRA, a claim must be submitted within one (1) year from the date of service.

If your benefits are denied by the Fund Office, you can appeal under the applicable procedures as described in the Post-Service Claims section of this booklet.

The HRA benefit is not insured and is funded solely by employer contributions. The Plan does not accept employee contributions to HRA accounts.

You can claim reimbursement from the HRA after a contribution is made to the HRA on your behalf. The HRA contributions do NOT expire at the end of a year under current tax rules. Any unused amount will roll over (without interest) to a following year until you have used your full HRA balance or forfeit your eligibility for HRA benefits. Your HRA balance will be forfeited if you have 36 months of no contributions or claims paid from your HRA account. If you are not enrolled in a level of coverage, another Group Health Plan, or COBRA, you may use your HRA but only up to the balance remaining in your HRA at the end of the last day of the Benefit Period in which you last had an active level of coverage.

Eligible Expenses

Current tax laws require that the Plan limit HRA benefits to payment of eligible health care expenses. The HRA account can be used to reimburse you for eligible health care expenses which:

- Are incurred and paid for you, your eligible Spouse and your eligible Children for eligible goods or services;
- Are for the diagnosis, cure, mitigation, treatment or prevention of disease or treatments affecting any part or function of the body;
- Are not otherwise compensable by (or the responsibility of) an insurance carrier, a health plan or other third party, and
- Could be claimed as a medical expense deduction on a federal income tax return (without regard to limitations on deductibility based on a percentage of your income).

The rules on eligible health care expenses generally follow the federal income tax rules in Section 213 of the Internal Revenue Code (IRC) for medical expense deductions (without the limitation to amounts over a percentage of adjusted gross income). IRS Publication 502 (Medical and Dental Expenses) has multi-page lists of eligible and ineligible expenses. The current version of IRS Publication 502 can be found on the IRS website, www.irs.gov.

Here are some general examples of out-of-pocket expenses you can claim for reimbursement under current IRS regulations:

- Co-payments or costs for medical services legally rendered by physicians, surgeons, dentists, and other medical practitioners not covered by other health insurance or plans
- Costs of durable medical equipment (including wheelchairs) and diagnostic devices needed for medical care
- Premiums you pay for insurance that covers the expenses of medical care (with some exclusions noted in Publication 502), ***with post-tax dollars***, including Medicare Part B and Medicare Part D premiums
- Ambulance costs
- Prescription drugs and co-payments, insulin and diabetic testing supplies
- Laboratory, X-rays, surgical, dental, therapy and other healing or diagnostic services
- Eye exams, glasses, contacts and laser surgery
- Hearing tests and hearing aids
- Dental exams, dental work and dentures

This is only a summary that is subject to ongoing IRS rules and changes in those rules.

An expense that is not eligible for payment from an employer-funded "Health Reimbursement Account" under the IRS rules on deductible medical expenses will not be an eligible HRA expense from the Plan.

IRS rules specify that, to be an eligible medical expense, medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses are not eligible medical expenses if they would be normal living expenses or are merely beneficial to general health.

You cannot claim the following expenses under current IRS rules:

- Claims for more than your actual cost;
- Expenses which would be incurred or paid without regard to sickness, such as food or lodging outside of hospital care;
- Expenses for your general health, such as a vacation or health club dues;
- Capital expenses which improve the value of property or which are not made primarily for medical care;
- Non-prescription medicines, nutritional supplements, vitamins, herbal supplements, "natural medicines";
- Household and personal care services, babysitting, childcare, except certain nursing-type services;
- Illegal operations and treatments, controlled substances under federal law (even if permitted by state law);
- Prescription or other drugs brought in (or ordered and shipped) from another country;
- Cosmetic surgery, weight-loss programs and similar items that do not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- Premiums for coverage under an ACA Marketplace Plan or other individual health insurance policy; or
- Employee payments or premiums for other group health plan coverage (such as a spouse's plan) that are paid with pre-tax dollars (namely, money that is not included in W-2 wages).

For more information on how to submit a claim for reimbursement from your HRA, please contact the Fund Office.

COBRA Continuation Coverage

Federal law requires that most group health plans (including this Plan) give participants and beneficiaries the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan.

COBRA coverage is limited to group health benefits. Continuation coverage provides the same group health benefits that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights to group health plan benefits under the Plan as other participants or beneficiaries covered under the Plan.

Specific information on your COBRA rights in specific circumstances and answers to your questions about continuation coverage can be obtained from the Fund Office. In order to protect your family's rights, you should keep the Fund Office informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Eligibility for Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries

who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Retirees will generally not be qualified beneficiaries because, in order to be a qualified beneficiary, a retiree must lose your coverage under the Retiree Plan because one of the following qualifying events happens and, the below events will not cause a loss of Retiree Plan coverage:

- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- you are laid off; or
- you retire.

Your family members will become a qualified beneficiary if they lose coverage under the Retiree Plan because any of the following qualifying events happen;

- you pass away;
- you become divorced or legally separated from your spouse; or
- your child stops being eligible for coverage under the plan as a "child."

Notice Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction of hours of employment, layoff, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), you or your employer must notify the Fund Office of the qualifying event within 30 days of any of these events.

YOU MUST NOTIFY THE FUND OFFICE of other qualifying events (divorce or legal separation of the employee and spouse or a child's losing eligibility for coverage as a child), **WITHIN SIXTY (60) DAYS AFTER THE QUALIFYING EVENT OCCURS.** Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries.

Length of Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage.

- In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a child ceasing to be an eligible family member under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid on time,
- the Retiree Plan is terminated.

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

Electing Continuation Coverage

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their children only. A qualified beneficiary must elect coverage by the date specified on the Election Form you receive from the Fund Office. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Cost of Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

Payment for Continuation Coverage

First payment for continuation coverage. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. You must deliver your first payment for continuation coverage to the Fund Office within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Fund Office to confirm the correct amount of your first payment.

Periodic Payments for Continuation Coverage. After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due in the Fund Office at least one day before the month for which you want to continue coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan sends monthly notices of payments due for these coverage periods.

Grace period. Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your 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.

If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose the right to continuation coverage under the Plan.

Alternative Health Coverage Besides Continuation Coverage

You may have the right, when your group health coverage ends, to enroll in an individual health insurance policy. The benefits provided under an individual conversion policy may not be identical to those provided under the Plan. You may exercise these rights in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you.

Health Insurance Marketplace

Additionally, instead of enrolling in COBRA Continuation Coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage.

The Health Insurance Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA Continuation Coverage. Being offered COBRA Continuation Coverage does not limit your eligibility for coverage or for a tax credit through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit:

www.HealthCare.gov.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit EBSA website at www.dol.gov/ebsa.

Special Enrollment Rights

If you or your eligible family members experience a Qualifying Life Event," you, your Spouse and/or Children may be eligible for "Special Enrollment" in this Plan or a group health plan provided by a Spouse's employer.

"Qualifying Life Events" include:

- birth, adoption or placement of child for adoption,
- divorce or other loss of a Spouse or Child,
- marriage
- loss of other medical coverage, or
- new medical coverage takes effect during the year.

Other medical coverage can include another employer-sponsored group health plan or Medicaid or CHIP benefits. If you fail to enroll yourself or your Spouse and Children because of other health insurance or group health plan coverage, a loss of that coverage occurs if you or your Spouse and Children lose eligibility for that other coverage or if the employer stops contributing the same amount for coverage so as to increase the cost of coverage under the other plan. A loss of other coverage also occurs if your eligible Children lose Medicaid or CHIP coverage because they are no longer eligible for such coverage.

Effective Date of Coverage after Special Enrollment

In the case of marriage, birth, adoption or placement of child for adoption, coverage will be effective on the date of the Qualifying Life Event if a completed enrollment form and proof of dependent status is returned to the Plan within 30 days of a Qualifying Life Event. Proof of dependent status includes providing the Fund Office with a social security number or taxpayer identification number for the eligible dependent. If the form is returned later, coverage will be effective on the first day of the month following the Plan's receipt of the form.

In the case of a loss of other group health plan or health insurance coverage (not including Medicaid or CHIP coverage), coverage will be effective on the first day of the month following receipt of enrollment materials by the Plan provided you request enrollment within 30 days of the date of you and/or your Spouse or Children lose coverage.

In the case of a loss of coverage under Medicaid or CHIP, your coverage will be effective as of the first day of the month following the submission of your enrollment materials provided that you request coverage within 60 days of the date your and/or your Spouse or Child's Medicaid or CHIP coverage is terminated.

Medicaid and CHIP Coverage

If you or your children are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you lose coverage under this Plan, CHIP or Medicaid, you, your Spouse and/or Children may be eligible for "Special Enrollment" under a group health plan provided by a Spouse's employer. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you lose coverage under the Plan, your children may be eligible for Medicaid or CHIP medical benefits. These programs may also have alternative coverage options for your eligible children. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your eligible family members might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. **Contact your State for more information on eligibility. To find a CHIP or Medicaid program in your state visit:**

For Medicaid: www.medicaid.gov

For CHIP: www.medicaid.gov/chip/state-program-information/index.html

Coordination of Benefits (COB)

On an annual basis, each Pre-Medicare Participant must complete an Annual Enrollment\Coordination of Benefits (COB) Form.

When a Retiree and his/her eligible family members are covered under two or more health care plans, COB determines which health care plan pays first for covered services.

If a claim is for covered services for an eligible family member who is eligible to join a second health care plan providing similar benefits, where all or a part of the cost of such health care plan is paid by the eligible family member or the eligible family member's employer, the health care benefit payment amount provided by this Plan will be limited to the amount needed, if any, to bring the benefit payment amount provided by such health care plan up to the scheduled amount of benefit provided by this Plan. This rule will apply even if the eligible family member does not in fact join the other health care plan.

Primary Rules for COB

The basic rules on coordination of benefits depend on the terms of other health care coverage and applicable law.

Generally, if the other health plan or insurance does not include rules for coordinating benefits, the other coverage will be primary.

If the other health plan or insurance includes rules for coordinating benefits, the order of payment will be as follows:

- This Plan is primary for employees,
- A spouse's own employer-sponsored plan, which if available must be elected, is primary for him/her,
- An adult child's own employer-sponsored plan, is primary for him/her,
- For children with two health care plans, the parent with the earliest birth date in the calendar year has the primary health care plan.

General Benefit Claim Exclusions

Benefits of any type under the Plan will not be paid if:

- You or your family members are not eligible for benefit coverage;
- The claim is submitted late, i.e. more than one (1) year past the date of service unless otherwise specified;
- The maximum allowance of the time limitation for any specific benefit has been reached;
- The claim is fraudulent, attempts a fraud, or misrepresents a fact;
- Your pension is suspended for any reason other than your return to work for a Contributing Employer.
- You enter into, participate, or cooperate with any employer in any arrangement, the purpose of which is to purposefully and fraudulently under report or under pay contributions to the Fund as required by the employer's Collective Bargaining Agreement within the Union; or
- The claim is for hospitalization, medical-surgical or any benefit for any occupational condition, ailment, injury or illness arising out of the course of employment pursuant to which the Retiree who is injured or ill is entitled to receive benefits under an applicable Workers' Compensation Law, Occupational Disease Law, or similar law granting benefits for like injury or disease.

The Fund may seek restitution for any money owed the Fund due to payment of benefits in error, in excess of Plan limits, or to or on behalf of a participant or family member not eligible for benefits, for any other reason, through the withholding of any monetary benefit payment due to the participant or family members.

No reimbursement will be made to or on behalf of any participant or eligible family member on account of services provided by a legally qualified professional provider who furnished services, if such provider is a member of the immediate family of the participant or an eligible family member.

Motor Vehicle Accident Coverage

If you suffer injuries in a motor vehicle accident, you are required to submit your claims relating to such injuries to your automobile insurer who will be the primary payer of any claims you incur. You are not permitted to waive your personal injury protection ("PIP") coverage to have the Plan be the primary payer of automobile-related claims. In the event your insurance carrier fails to pay medical coverage associated with a particular accident, please refer to the section in this SPD titled Subrogation and Reimbursement for details relating to the Plan's rules should you institute litigation against your auto insurance carrier.

Remedies for Fraud, Attempted Fraud, or Fraudulent Claims

If the Fund determines that your claim relates to a fraudulent act, attempts a fraud, or misrepresents a fact, the Board of Trustees may, in its discretion:

- Seek restitution for past payments made during the period of the fraud, through any lawful means, including the withholding of any monetary payments due to the covered participant, of monies paid to, or on behalf of, the individual perpetrating such fraud.

- Regardless of whether the delinquent contributions are ultimately collected and regardless of whether losses due to the fraud are ultimately recovered, suspend benefits immediately and pay no further

benefits to or on behalf of the covered participant and his/her eligible family members involved as to claims arising during the remainder of the Benefit Period in which such fraud or attempted fraud is discovered.

- Take such other and further actions as the Board may determine to be necessary.

The Board of Trustees shall have the final and absolute right to determine whether conduct described herein as fraud has been attempted or committed upon the Fund or Plan, and its determination shall be final, conclusive, and binding upon all parties.

Claims and Appeals

Please note that the Medical Benefits offered to Medicare-eligible Participants through Blue Advantage are insured and all appeals are handled through Blue Advantage and this section does not apply to those benefits. Information on how to submit a claim or appeal for those benefits is included within the Blue Advantage summary of benefits which is available at: www.members.carpenters.fund/benefit-coverage/blue-medicare-advantage/.

The chart below details to which Claims Administrators you should submit claims for benefits, other than Medicare-eligible Participant Medical Benefits, under the Plan. If your claim for benefits is denied, in whole or in part, you or a person authorized to act as your representative may appeal the decision.

The Plan has two levels of appeal for Pre-Medicare Participants' Medical and Mental Health and Substance Use Disorder Benefits, Prescription, Dental, and Vision Benefits. For these benefits, initial appeals must be filed with the claims administrator listed in the below chart. If you disagree with their decision on appeal, you may appeal to the Board of Trustees of the Fund in writing.

The Plan has one level of appeal for claims relating to eligibility, Fund Administered Benefits, and HRA benefits. If you disagree with a decision relating to such claims, you may appeal to the Board of Trustees of the Fund in writing.

The time limits applicable to claims and appeals are described in detail below.

Type of Benefit	Claims Administrator for filing claims	File Appeals with…..	(IF APPLICABLE) File Second Level Appeals with….
Plan Eligibility/ HRA Claims/Fund Administered Benefits	EASC Health Fund 1811 Spring Garden Street Philadelphia, PA 19130 Phone: (215) 538-0430 Fax: (215) 563-0169 health@carpenters.fund https://carpenters.fund/	The Board of Trustees of the EASC Health Fund 1811 Spring Garden Street Philadelphia, PA 19130 Phone: (215) 538-0430 Fax: (215) 563-0169 health@carpenters.fund https://carpenters.fund/	N/A

Type of Benefit	Claims Administrator for filing claims	File Appeals with…..	(IF APPLICABLE) File Second Level Appeals with….
Pre-Medicare Eligible Medical Benefits (Blue Card PPO)	Independence Administrators 1900 Market Street Philadelphia, PA 19103 (833) 242-3330 www.MYIBXTPAbenefits.com	Independence Administrators c/o Processing Center P.O. Box 21974 Eagan, MN 55121 (800) 810-2583 www.MYIBXTPAbenefits.com	The Board of Trustees of the EASC Health Fund 1811 Spring Garden St. Philadelphia, PA 19130 Phone: (215) 538-0430 Fax: (215) 563-0169 health@carpenters.fund https://carpenters.fund/
Pre-Medicare Eligible Mental Health Substance Use Disorder Benefits through Mental Health Consultants	Mental Health Consultants 1501 Lower State Road, Building D Suite 200 North Wales, PA 19454 (800) 255-3081 www.mhconsultants.com	Mental Health Consultants 1501 Lower State Road, Building D Suite 200 North Wales, PA 19454 (800) 255-3081 www.mhconsultants.com	The Board of Trustees of the EASC Health Fund 1811 Spring Garden St. Philadelphia, PA 19130 Phone: (215) 538-0430 Fax: (215) 563-0169 health@carpenters.fund https://carpenters.fund/
Prescription Drug Benefits	Express Scripts, Inc. 1 Express Way St. Louis, MO 63121 (800) 939-2146 www.express-scripts.com	Express Scripts, Inc. 1 Express Way St. Louis, MO 63121 (800) 939-2146 www.express-scripts.com	The Board of Trustees of the EASC Health Fund 1811 Spring Garden St. Philadelphia, PA 19130 Phone: (215) 538-0430 Fax: (215) 563-0169 health@carpenters.fund https://carpenters.fund/
Dental Benefits	CIGNA Dental PO Box 188037 Chattanooga, TN 37422 (800) CIGNA24	CIGNA Dental National Appeals Unit (NAO) PO Box 188011 Chattanooga, TN 37422 (800) CIGNA24	The Board of Trustees of the EASC Health Fund 1811 Spring Garden St. Philadelphia, PA 19130 Phone: (215) 538-0430 Fax: (215) 563-0169 health@carpenters.fund https://carpenters.fund/
Vision Benefits	Davis Vision 1900 Market Street Philadelphia, PA 19103 (800) 999-5431 www.davisvision.com	Independence Blue Cross Member Appeals P.O. Box 41820 Philadelphia, PA 19101 888-671-5276	The Board of Trustees of the EASC Health Fund 1811 Spring Garden St. Philadelphia, PA 19130 Phone: (215) 538-0430 Fax: (215) 563-0169 health@carpenters.fund https://carpenters.fund/

Time Limits for Claims and Appeals Filing

You or an authorized representative may request plan benefits by filing a claim with the Fund Office within 1 year from the date on which a claim arose, namely the date that health benefits or services were incurred or the date of death with respect to death benefits. The deadline may be earlier for specific benefits as described in the applicable benefit sections of this booklet.

	Urgent Care	Concurrent Service	Pre-Service	Post-Service	Disability
Claims Administrator must make initial claim determination as soon as possible but no later than:	72 hours	Before benefit is reduced or treatment is terminated	15 days	30 days	45 days
Extension permitted during initial benefit determination?	No	No	15 days	15 days	Up to 30 days (and if necessary an additional 30 days)
Appeal request must be submitted to the Applicable Claims Administrator within:	180 days	180 days	180 days	180 days	180 days
Appeal determination must be made as soon as possible but no later than:	72 hours	Before benefit is reduced or treatment is terminated	15 days	30 days for Medical, Mental Health and Substance Use Disorder, Prescription, Dental, and Vision Benefits; for all other benefits, next Trustees meeting that is at least 30 days after the Trustees receive the appeal	Next Trustees' meeting that is at least 30 days after the Trustees receive the appeal
For Medical, Mental Health and Substance Use Disorder, Prescription, Dental, and Vision Benefits, must make second level appeal request to the Board of Trustees of the Plan no later than:	180 days	180 days	180 days	180 days	N/A

Claim Determinations

If you make a claim for benefits that is denied, you must receive notification in writing in accordance with the requirements for Urgent Care, Concurrent Service, Pre-Service, Post-Service, Disability and Death Claims as explained below. If your claim is denied because more information is needed to make a decision, you must be notified of what information is needed.

Please note that the Fund's claims administrators are subject to the time restrictions below with respect to the benefits they administer. You should notify the Fund Office in the event that your claim with any claims administrator is not processed in a timely fashion.

Urgent Care Claims

An urgent care claim is involved if, in the opinion of your physician, you would be subject to severe, unmanageable pain absent the care or treatment for which you are claiming coverage. An urgent care claim is also involved if your

life or health would be seriously jeopardized if the Plan's determination with respect to your claim were made in the time period allowed for non-urgent treatment decisions.

You will be notified of the Plan's benefit determination as soon as possible, taking into account the medical emergencies of the case, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant (or representative of the claimant) fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, you will be notified as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The participant will be notified of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.

Concurrent Care Decisions

Concurrent care decisions are those that are made in connection with an approved course of treatment that is provided over a period of time or through a number of treatments. You will be notified of any reduction or termination involving concurrent care or ongoing treatment with sufficient time to allow you to appeal the reduction or termination before it is implemented. Special rules apply where the Plan has approved an ongoing course of treatment either for a specific period of time or for a specific number of treatments.

A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial, except if it occurs due to a Plan amendment or termination. In this case, a Plan Participant will be notified in advance so that the claimant can appeal the decision before the benefit is reduced or terminated.

The claimant may request to extend the course of treatment beyond the approved time period or number of treatments. If this involves urgent care, the Plan will notify the claimant whether the claimant's request has been approved or rejected within 24 hours of receiving the claimant's request, as long as the claimant makes the request at least 24 hours before the approved time period for reduction or number of treatments expires.

Pre-Service Claims

A "pre-service claim" is any claim or request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A participant will be notified of the Plan's benefit determination within a reasonable period of time appropriate to the circumstances, taking into account any pertinent medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 15 days provided that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 15-day period. The notice to the Plan Participant will state the reason for the extension and the date by which the Plan expects to render a decision. If the extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension must describe the required information. The Plan Participant will then have 45 days from receipt of the notice within which to provide the specific information.

In the case of a failure by a claimant or an authorized representative of a claimant to follow the Plan's procedures for filing a pre-service claim, the participant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the participant or representative as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim properly involving urgent care) following the failure. Notification may be oral, unless the Plan Participant or authorized representative request written notification.

Post-Service Claims

"Post-service claims" are any claims that are not pre-service claims. A participant will be notified of the Plan's benefit determination with a reasonable period of time appropriate to the circumstances, taking into account any pertinent medical circumstances, but not later than 30 days after receipt of the claim by the claim administrator.

Manner and Content of Notification of Benefit Determination

If the Claims Administrator issues a benefit denial, the denial will be in writing to the claimant in plain language. The claim decision will include:

1. The specific reason for the determination;
2. Reference to the plan provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures applicable to the claim, including the claimant's right to bring a civil action under ERISA following an adverse benefit determination following review by the Fund's Board of Trustees;
5. If an internal rule, guideline, protocol or other criteria was relied upon in making the determination, either the specific rule, guideline, protocol, or other criteria or a statement that a copy of the same will be provided free of charge upon request or does or does not exist; and
6. If the determination was based on medical necessity, experimental treatment, or a similar limit or exclusion, an explanation of the judgment for the determination as applied to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.

In the case of a Benefit Denial involving a claim for urgent care, the information may be provided orally within the time frame prescribed, with a written or electronic notification furnished to the Plan Participant not later than 3 days after such oral notification, and a description of the expedited review process applicable to such claims will be provided.

In the case of a benefit denial regarding disability benefits, in addition to the information described above,

1. An explanation of the basis for disagreeing with or not following:
    - The views you presented to the Plan of the health care and vocational professionals who treated or evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Pan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination; and
2. A statement describing that, if your claim is denied, you have the right to:
    - Submit additional proof of entitlement to benefits in advance of the Trustees' review of any appeal you submit; and
    - To examine any plan documents that are related to your claim for disability benefits (regardless of whether it was relied upon) free of charge.
3. A statement describing your right to a full, fair, and timely review by the Board of Trustees of all information relevant to your claim.

A document, record, or other information is relevant if it:

- Was relied upon by the Plan to make the decision;
- Was submitted, considered, or generated as part of the appeal process (regardless of whether it was relied upon); or
- Demonstrates compliance with the claims processing requirements.

Appealing a Denied Claim Internal Appeals

In General

You may appeal a benefit denial in writing within 180 days after you receive the denial.

Any appeal that does not involve urgent care must be in writing, and can be made by you or a duly authorized representative. It must set out the reasons for the appeal and your dissatisfaction or disagreement with the original determination. Any evidence, comments, or documentation to support your position should be submitted with your written appeal.

While an appeal is pending, any current course of treatment the claimant is undergoing will not be reduced or terminated nor, if the claim pertains to a rescission of your active coverage for reasons other than fraud or failure to pay a premium, will your active coverage be terminated.

Upon request and free of charge, you will be afforded reasonable access to, and copies of, all documents, records, and other information relevant to the claim. A claim review on appeal will not afford deference to the initial adverse benefit determination. The review will be conducted by an appropriately named fiduciary who is neither the individual nor subordinate of the individual who made the initial adverse determination. All written comments, documents, records, testimony and other information submitted by the claimant relating to the claim will be considered on appeal, regardless of whether or not such information was submitted or considered in the initial adverse benefit determination.

If an appeal involves medical judgment, including determinations with regard to medical necessity and whether a particular treatment, drug, or other item is experimental or investigational, the Claims Administrator or Trustees will consult with an independent health care professional with appropriate training and experience in the field of medicine involved. This health care professional will be someone who was neither an individual who was consulted in the initial adverse benefit determination or the subordinate of such individual. All medical or vocational experts whose advice was obtained in the initial adverse benefit determination will be identified by the Plan, upon request regardless of whether or not the individual's advice was relied upon in making the initial adverse benefit determination.

If the Claims Administrator or Trustees considers, relies upon, or generates any new or additional evidence or rationale when considering your claim it will provide this evidence or rationale to you as soon as possible in advance of the date a determination on your appeal is to be made. If the Claims Administrator or Trustees provide you with such new information, you have the right to respond and submit additional evidence or arguments before the Plan's deadline for issuing a decision on your appeal.

Initial Internal Appeals of Medical, Mental Health and Substance Use Disorder, Prescription, Dental, and Vision Benefits

If you submit a claim to one of the Plan's Claims Administrators and disagree with the decision by that Administrator, you must first appeal to the Claims Administrator directly. The Plan's Claims Administrators are subject to the requirements for Urgent Care, Concurrent Service, Pre-Service, and Post-Service Appeals as explained below. You should notify the Fund Office in the event that your appeal with a Claims Administrator is not processed in a timely fashion.

For initial appeals the time period in which the Claims Administrator or the Plan will review your appeal and notify you of its decision varies depending on the type of treatment or services to which your appeal relates as follows:

Urgent Care Appeals: In case of urgent care, there is an expedited review process where you can call or write the Plan Administrator and where all necessary information regarding the review will be provided to you promptly. You will be notified of a decision on appeal with respect to a claim involving urgent care as soon as possible but no later than 72 hours after the appeal request has been received.

Concurrent Care Appeals: In case of concurrent care decisions, you will be notified of a decision on appeal with respect to a claim involving concurrent care prior to the termination of the benefit if the appeal is received prior to such event, or within a reasonable period of time but no later than 30 days after the appeal request has been received if the benefit has been terminated.

Pre-Service Appeals: You will be notified of a decision on appeal with respect to a pre-service claim within a reasonable period of time but no later than 30 days after the appeal request has been received.

Post-Service Appeals: You will be notified of a decision on appeal with respect to a post-service claim within a reasonable period of time but no later than 60 days from the date the request has been received.

Manner and Content of Adverse Benefit Determination for First Level Appeals

If the Claims Administrator issues a denies your appeal they will do so in writing to the Plan Participant in plain language and in a culturally and linguistically appropriate manner. The claim decision will include:

1. The specific reason for the determination;
2. Reference to the plan provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures applicable to the claim, including the claimant's right to bring a civil action under ERISA following an adverse benefit determination following review by the Fund's Board of Trustees;
5. If an internal rule, guideline, protocol or other criteria was relied upon in making the determination, either the specific rule, guideline, protocol, or other criteria or a statement that a copy of the same will be provided free of charge upon request or does or does not exist; and
6. If the determination was based on medical necessity, experimental treatment, or a similar limit or exclusion, an explanation of the judgment for the determination as applied to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.

Second Level Appeals and Appeals of eligibility, vacation, death and AD benefits, Fund Administered Benefits, and HRA benefits

If you disagree with a Claims Administrator's determination after a first level review or the Plan's determination of your claim for eligibility, vacation, death and AD benefits, HRA benefits, or any Fund Administered Benefits, you may submit an appeal to the Board of Trustees within 180 days of the denial in writing to the address listed in the chart at the beginning of this Claims and Appeals section of the SPD.

The Board of Trustees will make a determination at their next regularly scheduled quarterly Trustees' meeting following its receipt of your appeal, provided they receive the appeal within 30 days of that meeting. If the appeal is received within 30 days of that meeting, they will hear the appeal at the meeting following their next regularly scheduled quarterly meeting. You will be provided with a written (or electronic, as applicable) notification of their appeal determination no later than 5 days after the Trustees' decision on appeal. If special circumstances require (e.g. the Trustees require additional information regarding the appealed claim), this period may be extended upon notice to the claimant but in no event shall the appeal be heard later than the third regularly scheduled Trustees' meeting following the Plan's receipt of the appeal.

The Board of Trustees normally will consider an appeal of a death benefit claim determination at their regular meeting scheduled at least 30 days after the appeal is received absent other notice. Special circumstances may require an extension of time for consideration of an appeal to no later than the third meeting of the Board following the Plan's receipt of the review request. You will be notified in writing of any such extension prior to the commencement of the extension. This notice will include the special circumstances for which the extension is required and the date by which the Plan expects to render a decision on the appeal. You will be notified of the Plan's decision on appeal in writing as soon as possible but not later than 5 days after the determination is made.

You do not have to exhaust all Claims Administrators' procedures or state insurance remedies in order to file a lawsuit under ERISA; however, you are required to exhaust your right of appeal to the Board of Trustees in order to pursue a lawsuit under ERISA.

The Claims Administrators or Fund Office may request additional information to clarify any matters it deems appropriate.

Manner and Content of Notification of Benefit Determination following Board of Trustee Review

In the event that an appeal is denied, the claimant will be notified electronically or in writing in a culturally and linguistically appropriate manner. The notice will include:

1. The specific reason(s) for the determination;
2. The specific plan provisions on which the determination was based;
3. A statement that the claimant is entitled to receive upon request and free of charge, reasonable access to copies of all documents, records or other information relevant to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA within one year of the denial of his or her claim;
5. If an internal rule, guideline, protocol or other criteria was relied upon in making the determination, a copy of the same or a statement that a copy of the same will be provided free of charge upon request or does not exist; and
6. If the determination was based on medical necessity, experimental treatment, or a similar limit or exclusion, a copy of the same or a statement that an explanation of the judgment for the determination as applied to the claimant's medical circumstances will be provided free of charge upon request.

For appeals of disability benefits, the notice will also include an explanation of the basis for disagreeing with or not following:

- The views you presented to the Plan of the health care and vocational professionals who treated or evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Pan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination; and

If the Trustees fail to follow the claims appeals procedures as outlined above, you will have the right to bring a civil action in court under Section 502(a) of ERISA.

The Board of Trustees can establish rules and regulations for administration of the Plan consistent with its obligations. The Board of Trustees' construction, interpretation or application of the Plan and Plan documents, including factual determinations

and eligibility determinations, is final, conclusive and binding on all persons.

The Board of Trustees makes the final decisions on participant benefit eligibility and on claims for benefits paid by the Plan.

External Appeals – Essential Health Benefits

A new appeal level has been added for the following essential health benefits:

- Ambulatory patient services
- Emergency services, including air ambulance services
- Hospitalization
- Maternity & newborn care
- Mental health & substance use disorder services
- Prescription drugs
- Rehabilitative services & devices
- Laboratory services
- Preventative & wellness services
- Pediatric services, including oral & vision
- Air ambulance services

If your initial claim for an essential health benefit was denied by the Fund office, and you subsequently appealed the Fund denial to the Board of Trustees, and you are unsatisfied with the decision of the Board on your appeal, you have a right to an external review of your appeal by an Independent Review Organization (IRO).

External review does not apply if your appeal pertains to your eligibility to receive benefits under the Plan. Eligibility claims are not eligible for external review, but all other medical claims for essential benefits may be appealed to an external IRO.

You have four months from the date of receipt of an adverse benefit determination to file a request for external review with the Fund Office. The Plan will notify you within six (6) days following the receipt of your request for expedited external review whether or not your claim is accepted for external review. It will not be accepted for external review if you did not exhaust the Fund's internal appeal step or if your claim pertains to a matter not subject to external review, such as a Plan eligibility claim or a non-essential health benefit claim.

The Plan will also notify you within this same time period if your appeal is incomplete because you failed to provide needed documentation. If your claim is incomplete you will have the longer of the initial four month period to file an external appeal or 48 hours to provide the missing information otherwise the Plan may consider your appeal a non-expedited request for review.

If your claim is accepted for external review, the Fund Office will send the claim and all supporting documentation to an IRO. The Fund will rotate each external appeal between the three IROs. The IRO will notify you when it receives your request for external appeal from the Fund Office and give you an additional ten business days to submit additional information if you so choose. If you submit additional information the Plan will have the opportunity to review it and if it determines that your claim should be granted, the external appeal process will be terminated. The IRO will issue a decision within 45 days after it receives the request for review from the Fund Office.

You also have the right to request the Plan to process your appeal as an expedited external appeal if your claim is an urgent care claim.

The Fund has contracted with the following three IROs, which are authorized to review eligible adverse benefit claim determinations:

NMR (National Medical Reviews), Inc.
260 Knowles Ave.
Suite 330
Southampton, PA 18966

MES Group
100 Morse Street
Norwood, MA 02062

IMX Medical Management Services, Inc.
1700 Paoli Pike
Malvern, PA 19355

Hardship Exceptions

The Board cannot change any insurance policy for insured benefits. For self-insured benefits, the Board has discretion to waive terms of the Plan, including, but not limited to, applicable time limits, or extend benefits to the extent the Board determines it is prudent to do so under the circumstances.

Assignment of Benefits Prohibited

You are expressly prohibited from assigning the benefits to which you are entitled under this Plan or your rights under ERISA with respect to this Plan to any third-party. In the event you obtain services from an out-of-network provider, payment will be made to you as the plan participant and it will be your responsibility to pay the out-of-network provider. You may **not assign your benefits to any provider and**

the Plan will not honor any assignment you make to a provider for any reason. The Plan may, however, in its sole and exclusive discretion pay an out-of-network provider directly without waiver of this prohibition against assignments.

In accordance with the Plan's claims and appeals procedures, the Plan will allow a personal representative authorized by you to act on your behalf for purposes of pursuing your claims and appeals rights under the Plan. The Plan's recognition of a personal representative for this purpose shall not be construed as a waiver of the Plan's prohibition against assignments described above.

Lawsuits and Limitations

A claimant who is dissatisfied with an eligibility determination or benefit determination, or who is otherwise adversely affected by any action of the Board or Plan must exhaust the Plan remedies before any lawsuit. The Plan has no voluntary mediation or arbitration procedures and is not subject to nor bound by arbitration awards under collective bargaining agreements. A claimant who has exhausted Plan remedies may proceed with a lawsuit in accordance with federal law.

The Plan has a one-year limitations period on lawsuits, regardless of the state in which the lawsuit is filed. This rule also applies to any administrative proceedings, arbitration, or other legal actions on such a claim or other action or for any amount claimed to be payable from the Plan or its fiduciaries in connection with a claim or other action (including without limitation, monetary remedies or awards for failure to respond to a request for documents or retroactive payments) against the Plan or its fiduciaries.

The one-year limitations period ends one year after the final denial of an appeal or, if not appealed, the last denial of a claim, or other event (including, without limitation, a date of death or disability or a request for plan documents) giving rise to a claim for payment or reimbursement from the Plan or its fiduciaries. Notwithstanding the general rule, no administrative proceedings, arbitration, lawsuit or other legal action amount shall be instituted after the last day on which the participant or Plan can sue an insurer or other claims administrator handling or paying any benefit under the Plan and no amount shall be payable from the Plan or its fiduciaries on any such barred claim.

Subrogation and Reimbursement for Other Party Liability

This provision applies when the Plan has paid any benefits on your or your eligible family member(s)' behalf in situations where another person or organization, including other insurance companies, is responsible for the payment of those expenses. Automobile accident injuries, injuries on the job, injuries caused by another person, or personal injury suffered on another's property are examples of cases subject to this provision. If you receive recovery or remuneration from a third party after you received benefits from the Plan, the Plan has a right of reimbursement and/or subrogation with respect to any and all proceeds you (or your eligible family member(s)) receive from any third party. These rights apply to the lesser of the amount recovered or the amount of benefits paid or payable by the Plan to or for you or for your eligible family member(s). The Plan's reimbursement and subrogation rights apply regardless of whether you or your eligible family members are made whole from any third-party recovery. The Plan will not be responsible for the attorney fees or costs of you or your eligible family member(s) in connection with any third party claim or right unless the Plan agrees in writing to pay for such fees or costs. These rules also apply to legal guardians or representatives of participants and eligible family members.

It is your duty to supply the Plan with any relevant information it needs for compliance with this provision, and refrain from any action that interferes with the Plan's rights. You may be requested to sign a subrogation and reimbursement agreement. Furthermore, you must notify the Plan, Independence Administrators and ESI of all covered services received that are related to the accident or illness.

In the event any payment is made by the Plan to an individual who is not entitled to payment or that any payment is made which exceeds the level of payment due under the term of this Plan, the Plan shall have the right to reduce future payments payable to such individual by the amount of such erroneous payment. This right of offset, however, shall not limit the right of the Plan to recover overpayments in any other manner.

If you or your eligible family member refuses to:

- Sign a subrogation and reimbursement agreement;
- Reimburse the Plan in accordance with these subrogation and reimbursement rules; or

- Cooperate with the Plan in its attempt to enforce these subrogation and reimbursement rules

Then, the Plan may:

- Deny benefits to any person who refuses to sign a subrogation and reimbursement agreement;
- Take necessary legal action to recover benefits paid;
- Adjust future benefit payments, including death benefit entitlements, to offset any uncollected payments due as a result of these subrogation and reimbursement provisions; or,
- Obtain other relief that is appropriate.

Due to controlling federal law, the Plan's self-funded benefits (including most Independence Administrators claims) generally are NOT subject to state law limits on subrogation or third-party recoveries.

General Information About the Plan

This section provides you with general information about how the Plan is administered.

Your Obligations

Pre-Medicare Participants must complete an Annual Enrollment/COB Form. You and your family member's eligibility for all benefits may be terminated or put on hold, as provided on the forms, if you fail to complete these forms on a timely basis.

Additionally, the Fund Office MUST be notified in writing if:

- You change your beneficiary.
- You get married or divorced. You must submit a copy of the marriage license, or a divorce decree, agreement, or a Qualified Domestic Relations Order.
- You add or drop a child. You must submit a copy of the birth or adoption certificate.
- An eligible family member passes away. You must submit a Death Certificate.
- You change your address.
- An eligible family member acquires, terminates or changes his/her benefit coverage through his/her employer.

Your coverage and benefits may be delayed or reduced in the absence of timely written notice. The Plan may also recover any overpayment of benefits or other losses resulting from a failure to provide notice on a timely basis in writing.

Plan Name

Retiree Plan of the Eastern Atlantic States Carpenters Health Fund

Type of Plan

This Plan is a collectively-bargained, multi-employer welfare plan. The Plan is a group health plan with respect to hospital, surgical, and other health care benefits such as dental, prescription, vision and mental health benefits. The Plan is intended to comply in all respects with the requirements of Title I of ERISA and other applicable law.

The Plan is self-administered and self-insured for all benefits paid under the Retiree Plan with the exception of the Blue Advantage Plan for Medicare-eligible Participants which is insured. The actual day-to-day administration of the Plan is carried out at the Fund Office that was established for this purpose by the Board of Trustees. The Executive Director of the Fund, who is appointed by the Board of Trustees, and his/her office staff conduct the day-to-day administration of the Plan.

Plan Number

501

Employer Identification Number

22-6032181

Plan Year

January 1 through December 31 (Benefit Year is April 1 through March 31)

Agent for Service of Legal Process

Kroll Heineman Ptasiewicz & Parsons LLC
99 Wood Avenue South, Suite 307
Iselin, New Jersey 08830

Susanin Widman & Brennan, P.C.
1001 Old Cassatt Rd, Suite 306
Berwyn, PA 19312

You may also serve legal process on a member of the Board of Trustees.

Contributing Employers

The Plan is supported primarily by contributions made by Employers. A list of contributing Employers is available for your review at the Fund Office.

The Plan is maintained and contribution amounts are determined according to the provisions of Collective Bargaining Agreements between the Union and/or the Association and/or Employers. Copies of the Collective Bargaining Agreements are available in the Fund Office.

Plan Administrator

The Administrator of the Plan is the Board of Trustees of the Trust Fund. The Board of Trustees includes 28 Members. The Union appoints 14 members, and the Associated Construction Contractors of New Jersey appoints 7 members and the General Building Contractors Association appoints 7 members.

Although the Board intends to continue the Plan indefinitely, they reserve the right to amend or terminate the Plan at any time.

The assets of the Plan are held in a Trust Fund under a Trust Agreement. The Board of Trustees may, in its discretion, delegate management of certain Fund assets to an investment manager.

The basic financial records of the Plan and the Trust are maintained on a fiscal year basis. The Benefit Year is the period from April 1 through the following March 31 while the Fiscal Year is January 1 through December 31.

Cost

The Plan is funded primarily by Employer contributions for work in Covered Employment, as required by the Collective Bargaining Agreement between the Union and your Employer(s) and by Participant or eligible family member contributions made pursuant to the Plan or applicable law. All contributions and earnings are held in a Trust Fund under a Trust Agreement.

Executive Fund Director

Mr. Pete Tonia
Executive Fund Director
Eastern Atlantic States Carpenters Health Fund
1811 Spring Garden Street
Philadelphia, PA 19130
Phone: (215) 568-0430
health@carpenters.fund
https://carpenters.fund/

Plan Amendment or Termination

The Trust Agreement or Plan may be amended or terminated at any time by mutual agreement of the Union and Associations or by vote of the Board of Trustees at a meeting called by written notice. Upon termination of the Fund, ERISA and Internal Revenue Code rules governing the Fund provide that remaining assets must be distributed to pay outstanding benefits, and then to participants for the payment of life, sick, accident, or other benefits to the members of such association or their eligible family members or designated beneficiaries.

The Plan is a multiemployer plan and will not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, other than

- for nonpayment of contributions;
- for fraud or other intentional misrepresentation of material fact by the employer;
- for noncompliance with material Plan provisions;
- because the plan is ceasing to offer any coverage in a geographic area;
- for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

In the case of a benefits provided through a network plan, benefits may terminate if there is no longer any individual enrolled in the Plan who lives, resides, or works in the service area of the network plan. The Plan will apply this rule uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their eligible family members.

ERISA Rights

The following statement of your rights under the Employee Retirement Income Security Act of 1974 ("ERISA") is furnished in compliance with ERISA Section 104(c). As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all

documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of plan documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. For 2009 and subsequent plan years, you may obtain an electronic copy of the plan's annual report by going to www.efast.dol.gov and using the Form 5500 search function.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Under ERISA, you may continue health care coverage for yourself, spouse or children if there is a loss of coverage under the plan as a result of a qualifying event. You, your spouse, or your children may have to pay for such coverage. Review this summary plan description and documents governing the plan on the rules governing your COBRA Continuation Coverage rights.

ERISA provides for reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You will be provided a certificate of creditable coverage upon request, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied, in whole or in part, you are entitled to receive a written explanation of the reason for the denial and copies of the documents relating to the decision without charge. Also, you have the right to appeal any denial, all within specific time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request copies of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such cases, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may have a right to file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court after you have exercised all claim and appeal rights within the time limits stated in the plan document and summary plan description unless you are legally excused from those procedures. If it should happen that plan fiduciaries misuse the plan's money or that you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. The court also may impose sanctions against you if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should

contact the nearest Area Office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Use and Disclosure of Protected Health Information

Privacy of PHI under HIPAA

The Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides procedures to safeguard your Protected Health Information. "Protected Health Information" is defined in government regulations and generally is any information about your past, present or future physical or mental health condition or payment for care that identifies or could be used to identify you. Any terms used in this section have the meanings set forth in the regulations issued under the Health Insurance Portability and Accountability Act.

As required by HIPAA, the Board of Trustees and Plan will:

- Authorized Use or Disclosure. Only use or disclose Protected Health Information as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

- Subcontractors and Agents. Require each agent and subcontractor to whom it provides Protected Health Information to agree to written contractual provisions that the agent or subcontractor will be subject to the same restrictions and conditions that apply to the Plan with respect to Protected Health Information.

- Permitted Purposes. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the employers who contribute to the Plan or the Fund's office.

- Reporting. Report and record uses or disclosures of Protected Health Information that are inconsistent with those permitted by law of which they become aware.

- Protected Health Information Availability. Make Protected Health Information available to Participants and their Eligible family members at the Fund Office so that they can inspect and copy their own individual Protected Health Information.

- Protected Health Information Correction. Permit Participants and their Eligible family members to amend or correct Protected Health Information that is incorrect or incomplete. The Plan will incorporate any such amendments or corrections provided into Plan records.

- Accounting. Make Protected Health Information available to permit the Plan to provide an accounting of disclosures.

- Government Agencies. Make internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Department of Health and Human Services for purposes of determining the Plan's compliance with the Health Insurance Portability and Accountability Act of 1996.

- Return or Destruction of Protected Health Information. Return or destroy all Protected Health Information received from the Plan that the Board of Trustees or Plan maintains in any form will be if feasible, and no copies of such information will be retained, when such information is no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, further uses and disclosures will be limited to those purposes that make the return or destruction of this information infeasible.

- Minimum Necessary Standard. Use their best efforts to request only the minimum necessary type and amount of Protected Health Information needed to carry out the functions for which the information is requested.

- Adequate separation. Take prudent measures to provide that adequate separation exists between the Plan and other offices or plans of the Union or employers so that Protected Health Information will be used only for the Plan administration functions performed by the Union, employers or other plans for the Plan. For purposes of establishing adequate separation, the Board of Trustees will certify the employees or classes of employees of the common Fund Office who will have access to Protected Health Information for Plan administration purposes.

In addition, the Board of Trustees and Plan will report improper uses or disclosures of Protected Health Information to the privacy official of the Plan or the privacy official's designee for handling HIPAA violations.

Non-compliance by a Business Associate

The Administration will not be liable for a breach of the HIPAA Privacy requirements by a Business Associate except as required by law.

Security of Protected Health Information

The Security Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides procedures to safeguard your "Electronic Protected Health Information". "Electronic Protected Health Information" is defined in government regulations and generally is any Protected Health Information that is created, received, maintained, or transmitted in electronic form. If any other provision(s) of this booklet conflicts with the requirements of this Section, this Section will control.

The Board of Trustees and Plan will safeguard Electronic Protected Health Information by:

- Administrative, Physical, and Technical Safeguards. Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information the Board creates, receives, maintains, or transmits on behalf of the Plan.

- Security of Adequate Separation. Ensuring that the "adequate separation" between the Plan and other offices or plans of the Union or employers described in the "Privacy of Protected Health Information" section is supported by reasonable and appropriate security measures.

- Subcontractors and Agents. Ensuring that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information.

- Reporting. Reporting to the security official of the Plan or the security official's designee any Security Incident of which it becomes aware.

These requirements do not apply to Electronic Protected Health Information that the Board of Trustees; (1) receives pursuant to an appropriate authorization that complies with HIPAA regulations or that qualifies as "Summary Health Information" and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending, or terminating the Plan as authorized by the HIPAA Privacy Rules. Summary Health Information is defined in HIPAA regulations and generally is claims data for the Plan from which most information that could be used to identify you individually is removed.

Hybrid entity

For purposes of complying with the HIPAA privacy and security rules, the Plan is a hybrid entity because it has both health plan and non-health plan functions. The Plan designates that the health care components covered by the HIPAA rules include only health benefit functions and not other Plan functions or benefits.

HITECH Breach Notification

HIPAA was amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which as enacted as part of the American Recovery and Reinvestment Act of 2009.

HITECH requires HIPAA-covered entities, such as the Plan, to respond to data breach events when unsecured protected health information is disclosed, accessed, or acquired by an unauthorized third party. The Plan must, within 60 days of knowledge of the data breach, notify the impacted individuals as well as the Department of Health and Human Services ("HHS"). If 500 or more people are affected, the Plan is required to give immediate notice to the media and the HHS, which will post notice of the breach on its website. In addition, plans must provide HHS with annual reports of all of their breaches each year, no matter the number.

Genetic Information and Non-Discrimination Act

The Plan may not disclose protected health information that is genetic information for underwriting purposes as this is prohibited by the Genetic Information Nondiscrimination Act ("GINA").

Board of Trustees

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