Carpenters and Joiners Welfare Fund

Summary Plan Description and Plan Document

For Participants of

The Carpenters and Joiners Welfare Fund

Amended and Restated Effective January 1, 2012
HOW TO USE THIS BOOK

This document has been revised to provide you with a thorough explanation of the benefits available to you and your family under this Plan. All defined terms used in this Plan are capitalized. A summary is provided in the box at the beginning of each section. These summaries provide you with an overview of the subjects discussed in each section and will be useful in answering many questions you have about the Plan. Of course, more details are provided after the summary of each section. You should always review the entire section or sections when determining what benefits you may be entitled to receive.

If you have any questions about the Plan, you should contact the Plan Administrator at (952) 854-0795 or (800) 535-6373.
To All Participants:

We are pleased to furnish you with this new Summary Plan Description and Plan Document (“SPD”). As Trustees of your health care plan, we want you to have all the information about your Plan including the eligibility rules, a description of the type and amount of benefits available, as well as any limitations and exclusions which may cause you to lose benefits. This SPD also provides you with instructions for filing a claim and tells you all of the requirements contained in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

However, the SPD can only be helpful if you use it. We urge you to read this SPD now and keep it available for future reference when you or your family need information about your health care benefits under the Plan.

We administer your Plan with the help of a Plan Administrator, administrative office staff, professional benefits consultants, legal counsel, and a certified public accounting firm. As Trustees of your Plan, we will continue to manage the Plan in a financially responsible manner and to keep the level of benefits in line with medical care costs as permitted by Plan income and reserves.

We hope that you will find this explanation of your Plan helpful. However, if you have any questions at any time regarding your Plan, please contact the Plan Administrator, Wilson-McShane Corporation, at (952) 854-0795 or (800) 535-6373.

Sincerely,

The Board of Trustees
IMPORTANT NOTICES

This SPD booklet is intended to give you a description of the life, disability, dental, vision and health care benefits adopted by the Trustees. It is the sole document that describes your eligibility and benefits. Only the full Board of Trustees has the authority to interpret the health care benefits described in this SPD booklet. Their interpretation will be final and binding on all individuals dealing with the Plan or claiming a benefit from the Plan. The Plan contains appeal procedures you may use if you feel you have been wrongfully denied benefits. Only after those appeal procedures are exhausted can you challenge the Trustees’ decision in Court. No Employer or Union nor any representative of any Employer or Union, in that capacity, is authorized to interpret this Plan nor can any such individual act as an agent of the Trustees. If you want any information regarding this Plan, the information must be communicated to you in writing signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees in writing, by the Plan Administrator.

Trustee Authority

The Board of Trustees has full authority to increase, reduce, or eliminate benefits and to change the eligibility rules or other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the Eligible Employees and their Dependents. The right to change or eliminate any benefits provided for Retirees and their Dependents is a right specifically reserved to the Trustees. Notices of any changes will be sent to each Eligible Employee’s last-known address within the time required by applicable regulations. Therefore, it is extremely important that you keep the Plan Administrator informed regarding any changes in your address. Changes, however, may take effect before you receive notification. Therefore, before receiving non-emergency care, you may wish to contact the Plan Administrator to confirm your current health benefits if you are unsure what they are.

Grandfathered Status Under the Patient Protection and Affordable Care Act

The Trustees believe this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (952) 854-0795 or toll free at 1-800-535-6373. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
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Service of legal process may also be made upon a Plan Trustee.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMARY OF BENEFITS</td>
<td>1</td>
</tr>
<tr>
<td>PLAN MAXIMUMS</td>
<td>1</td>
</tr>
<tr>
<td>Lifetime Major Medical Maximum</td>
<td>1</td>
</tr>
<tr>
<td>Annual Maximum Benefit for Essential Health Benefits</td>
<td>1</td>
</tr>
<tr>
<td>Major Medical Deductible (See “Calendar Year Deductibles”)</td>
<td>1</td>
</tr>
<tr>
<td>Annual Out-Of-Pocket Maximum (see “Maximum Out-of-Pocket Expense”)</td>
<td>1</td>
</tr>
<tr>
<td>COVERAGE FOR THE EMPLOYEE ONLY</td>
<td>2</td>
</tr>
<tr>
<td>COVERAGE FOR ALL ELIGIBLE INDIVIDUALS</td>
<td>3</td>
</tr>
<tr>
<td>Major Medical Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Maximum Limits for Major Medical Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Non-Major Medical Benefits</td>
<td>4</td>
</tr>
<tr>
<td>Maximum Limits for Non-Major Medical Benefits</td>
<td>5</td>
</tr>
<tr>
<td>ELIGIBLE INDIVIDUALS IN THE “SENIOR PLAN”</td>
<td>5</td>
</tr>
<tr>
<td>ELIGIBILITY</td>
<td>7</td>
</tr>
<tr>
<td>EMPLOYEES</td>
<td>7</td>
</tr>
<tr>
<td>Initial Eligibility</td>
<td>7</td>
</tr>
<tr>
<td>Continuing Eligibility</td>
<td>8</td>
</tr>
<tr>
<td>Maintenance of Eligibility for Employees Receiving Disability Benefits</td>
<td>9</td>
</tr>
<tr>
<td>Supplemental Reserve Credits</td>
<td>10</td>
</tr>
<tr>
<td>Self-Payment Procedures</td>
<td>10</td>
</tr>
<tr>
<td>Reinstatement of Eligibility</td>
<td>11</td>
</tr>
<tr>
<td>Termination of Eligibility and Cancellation of Supplemental Reserve Credits On Taking Certain Employment</td>
<td>11</td>
</tr>
<tr>
<td>Eligibility through Reciprocity</td>
<td>12</td>
</tr>
<tr>
<td>Classroom Contribution Credits for Apprentices</td>
<td>12</td>
</tr>
<tr>
<td>Opt-Out For Health Savings Account (HSA) Coverage</td>
<td>13</td>
</tr>
<tr>
<td>APPRENTICESHIP TRAINING BENEFIT</td>
<td>14</td>
</tr>
<tr>
<td>COVERAGE FOR ALUMNI EMPLOYEES</td>
<td>14</td>
</tr>
<tr>
<td>COVERAGE FOR YOUR DEPENDENTS AFTER YOUR DEATH</td>
<td>15</td>
</tr>
<tr>
<td>ELIGIBILITY DURING PERIODS OF MILITARY SERVICE</td>
<td>15</td>
</tr>
<tr>
<td>You must inform the Plan Administrator in writing as soon as you know that you are entering military service.</td>
<td>15</td>
</tr>
<tr>
<td>Freezing Coverage</td>
<td>16</td>
</tr>
<tr>
<td>Military Continuation Coverage</td>
<td>16</td>
</tr>
<tr>
<td>Coverage Following Military Service</td>
<td>17</td>
</tr>
<tr>
<td>Time limits to Return to Work or Report for work (If No Work is Available)</td>
<td>18</td>
</tr>
<tr>
<td>FAMILY AND MEDICAL LEAVE</td>
<td>18</td>
</tr>
<tr>
<td>Advance Notice and Medical Certification</td>
<td>18</td>
</tr>
<tr>
<td>Reasons for Taking FMLA Leave</td>
<td>19</td>
</tr>
<tr>
<td>Failure to Return from FMLA</td>
<td>20</td>
</tr>
<tr>
<td>Contribution While Out on FMLA Leave</td>
<td>20</td>
</tr>
<tr>
<td>State Family and Medical Leave Laws</td>
<td>20</td>
</tr>
<tr>
<td>FMLA Questions</td>
<td>20</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>RETIREE BENEFITS: “THE SENIOR PLAN”</td>
<td>20</td>
</tr>
<tr>
<td>CONTINUED ELIGIBILITY WHILE RETIRED</td>
<td>21</td>
</tr>
<tr>
<td>Election of Dental Coverage</td>
<td>23</td>
</tr>
<tr>
<td>Opting Out of Dental Coverage under the “Senior Plan”</td>
<td>23</td>
</tr>
<tr>
<td>Coverage for Eligible Dependents</td>
<td>23</td>
</tr>
<tr>
<td>Payment of Self-Contributions for Retiree Benefits</td>
<td>24</td>
</tr>
<tr>
<td>Opting out of Coverage under the Senior Plan</td>
<td>25</td>
</tr>
<tr>
<td>Coverage for Surviving Dependents of Retirees</td>
<td>28</td>
</tr>
<tr>
<td>Termination of Coverage for Retirees and Their Dependents</td>
<td>28</td>
</tr>
<tr>
<td>CONTINUING ELIGIBILITY THROUGH SELF-CONTRIBUTIONS (“CONTINUATION COVERAGE UNDER COBRA”)</td>
<td>30</td>
</tr>
<tr>
<td>Qualifying Events</td>
<td>30</td>
</tr>
<tr>
<td>Notification Responsibilities</td>
<td>31</td>
</tr>
<tr>
<td>Maximum Coverage Period</td>
<td>31</td>
</tr>
<tr>
<td>Self-Contributions Procedures and Rules</td>
<td>32</td>
</tr>
<tr>
<td>Special Enrollment Events</td>
<td>34</td>
</tr>
<tr>
<td>Termination of Continuation Coverage</td>
<td>34</td>
</tr>
<tr>
<td>LIFE BENEFIT</td>
<td>35</td>
</tr>
<tr>
<td>BENEFICIARY</td>
<td>35</td>
</tr>
<tr>
<td>TOTAL DISABILITY</td>
<td>36</td>
</tr>
<tr>
<td>LIMITATIONS</td>
<td>37</td>
</tr>
<tr>
<td>ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT</td>
<td>38</td>
</tr>
<tr>
<td>BENEFITS</td>
<td>38</td>
</tr>
<tr>
<td>BENEFICIARY</td>
<td>39</td>
</tr>
<tr>
<td>WEEKLY DISABILITY BENEFIT</td>
<td>40</td>
</tr>
<tr>
<td>ELIGIBILITY FOR BENEFITS</td>
<td>40</td>
</tr>
<tr>
<td>INDEMNITY LIMITS AND BENEFIT PROVISIONS</td>
<td>40</td>
</tr>
<tr>
<td>AMOUNT AND COMMENCEMENT OF BENEFITS</td>
<td>41</td>
</tr>
<tr>
<td>SUCCESSIVE PERIODS OF DISABILITY</td>
<td>41</td>
</tr>
<tr>
<td>WEEKLY DISABILITY BENEFIT EXCLUSIONS AND LIMITATIONS</td>
<td>42</td>
</tr>
<tr>
<td>TAXATION OF WEEKLY DISABILITY BENEFITS</td>
<td>42</td>
</tr>
<tr>
<td>MAJOR MEDICAL BENEFIT</td>
<td>43</td>
</tr>
<tr>
<td>PREFERRED PROVIDER NETWORK</td>
<td>43</td>
</tr>
<tr>
<td>CALENDAR-YEAR DEDUCTIBLES</td>
<td>44</td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>44</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>44</td>
</tr>
<tr>
<td>PLAN BENEFITS PAID</td>
<td>44</td>
</tr>
<tr>
<td>DEDUCTIBLE RULES</td>
<td>44</td>
</tr>
<tr>
<td>LIFETIME MAXIMUM BENEFIT</td>
<td>45</td>
</tr>
<tr>
<td>MAXIMUM OUT-OF-POCKET EXPENSE</td>
<td>45</td>
</tr>
<tr>
<td>COVERED MEDICAL EXPENSE EXPENSE</td>
<td>47</td>
</tr>
<tr>
<td>HOSPITAL EXPENSE BENEFIT</td>
<td>47</td>
</tr>
<tr>
<td>Room and Board</td>
<td>47</td>
</tr>
<tr>
<td>Maternity Expenses</td>
<td>47</td>
</tr>
<tr>
<td>Other Hospital Expenses</td>
<td>48</td>
</tr>
<tr>
<td>TRANSPORTATION SERVICES</td>
<td>48</td>
</tr>
<tr>
<td>Table of Contents</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>PROPHYLACTIC MASTECTOMY AND OOPHORECTOMY BENEFIT ........................................ 49</td>
<td></td>
</tr>
<tr>
<td>CONVALESCENT FACILITY BENEFIT ........................................................................ 50</td>
<td></td>
</tr>
<tr>
<td>Limitations and Exclusions ............................................................................. 51</td>
<td></td>
</tr>
<tr>
<td>HOME HEALTH CARE BENEFIT ................................................................................ 51</td>
<td></td>
</tr>
<tr>
<td>Limitations and Exclusions ............................................................................. 51</td>
<td></td>
</tr>
<tr>
<td>HOSPICHE CARE BENEFIT .................................................................................... 52</td>
<td></td>
</tr>
<tr>
<td>Limitations and Exclusions ............................................................................. 54</td>
<td></td>
</tr>
<tr>
<td>REPLACEMENT OF ORGANS AND TISSUE BENEFIT .................................................... 54</td>
<td></td>
</tr>
<tr>
<td>Procedures Not Subject to Special Requirements .......................................... 54</td>
<td></td>
</tr>
<tr>
<td>Procedures Subject to Special Requirements ................................................ 55</td>
<td></td>
</tr>
<tr>
<td>Special Requirements for Transplant Procedures ............................................ 56</td>
<td></td>
</tr>
<tr>
<td>DEVELOPMENTAL DELAY THERAPY SERVICES ....................................................... 58</td>
<td></td>
</tr>
<tr>
<td>OTHER MAJOR MEDICAL BENEFITS ...................................................................... 59</td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH EXPENSE BENEFIT .................................................................... 63</td>
<td></td>
</tr>
<tr>
<td>FAMILY ASSISTANCE PROGRAM PROVIDED THROUGH T.E.A.M., INC. ........................ 63</td>
<td></td>
</tr>
<tr>
<td>How to Use Your Family Assistance Program .................................................. 64</td>
<td></td>
</tr>
<tr>
<td>TREATMENT OF MENTAL OR NERVOUS DISORDERS .............................................. 64</td>
<td></td>
</tr>
<tr>
<td>Additional Mental Health Assessment Benefit ............................................... 65</td>
<td></td>
</tr>
<tr>
<td>TREATMENT OF CHEMICAL DEPENDENCY ............................................................ 65</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit .............................................................................................. 66</td>
<td></td>
</tr>
<tr>
<td>Detoxification Treatment .................................................................................. 66</td>
<td></td>
</tr>
<tr>
<td>In-Patient Rehabilitative Treatment .................................................................. 66</td>
<td></td>
</tr>
<tr>
<td>Out-Patient Rehabilitative Treatment ................................................................ 66</td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH EXPENSE BENEFIT EXCLUSIONS ............................................. 67</td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH EXPENSE BENEFIT LIMITATIONS ............................................. 69</td>
<td></td>
</tr>
<tr>
<td>VISION EXPENSE BENEFIT .................................................................................. 70</td>
<td></td>
</tr>
<tr>
<td>VISION BENEFIT ............................................................................................... 70</td>
<td></td>
</tr>
<tr>
<td>COVERED EXPENSES ......................................................................................... 70</td>
<td></td>
</tr>
<tr>
<td>EXCLUSIONS AND LIMITATIONS ........................................................................ 72</td>
<td></td>
</tr>
<tr>
<td>DENTAL BENEFITS ............................................................................................ 74</td>
<td></td>
</tr>
<tr>
<td>SUMMARY OF DENTAL BENEFITS ...................................................................... 74</td>
<td></td>
</tr>
<tr>
<td>PLAN PAYMENTS ................................................................................................ 75</td>
<td></td>
</tr>
<tr>
<td>Claim Payments ............................................................................................... 75</td>
<td></td>
</tr>
<tr>
<td>Procedure for Submitting Claims .................................................................... 75</td>
<td></td>
</tr>
<tr>
<td>Prestatement of Costs - Estimate of Benefits ............................................... 75</td>
<td></td>
</tr>
<tr>
<td>Benefit Maximums ............................................................................................ 76</td>
<td></td>
</tr>
<tr>
<td>Deductible ........................................................................................................ 76</td>
<td></td>
</tr>
<tr>
<td>Coverage Period ............................................................................................... 76</td>
<td></td>
</tr>
<tr>
<td>DESCRIPTION OF COVERED PROCEDURES ...................................................... 76</td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preventive Services .................................................................. 77</td>
<td></td>
</tr>
<tr>
<td>Basic Services ................................................................................................. 77</td>
<td></td>
</tr>
<tr>
<td>Endodontics ...................................................................................................... 77</td>
<td></td>
</tr>
<tr>
<td>Periodontics ..................................................................................................... 78</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery ..................................................................................................... 78</td>
<td></td>
</tr>
<tr>
<td>Major Restorative Services ............................................................................. 78</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Repairs and Adjustments ................................................................ 79</td>
<td></td>
</tr>
</tbody>
</table>
The Carpenters and Joiners Welfare Fund Table of Contents

- Prosthetics: Removable and Fixed ................................................................. 79
- Orthodontics .................................................................................................. 79
- EXCLUSIONS FROM COVERAGE .................................................................. 80
- PRESCRIPTION DRUG BENEFIT ................................................................. 82
  - PRESCRIPTION DRUG BENEFITS .............................................................. 82
  - EXCLUSIONS AND LIMITATIONS .............................................................. 82
- HIGH-RISK INSURANCE POOL BENEFIT .................................................. 84
  - HIGH-RISK INSURANCE POOL BENEFIT ................................................ 84
- PLAN CONDITIONS, LIMITATIONS AND EXCLUSIONS ......................... 86
- RETIREE BENEFITS: "THE SENIOR PLAN" .................................................. 96
  - Eligible Individuals in the "Senior Plan" under 65 Years of Age ............... 96
  - Eligible Individuals in the "Senior Plan" age 65 and above .................... 96
- PAYMENT OF BENEFITS ............................................................................. 97
- RULES GOVERNING PAYMENT OF BENEFITS .......................................... 97
  - Payments to those Eligible for Medical Assistance ............................... 101
- COORDINATION OF BENEFITS ................................................................. 101
  - Definitions Applicable to these Coordination of Benefits Provisions ....... 102
  - Order of Benefit Payments ....................................................................... 104
- COORDINATION OF BENEFITS WITH OTHER TYPES OF INSURANCE .... 106
- COORDINATION OF BENEFITS WITH AUTOMOBILE INSURANCE ......... 106
- COORDINATION OF BENEFITS WITH MEDICARE ................................... 107
  - For Retirees Eligible For Medicare ......................................................... 107
  - For Individuals Under 65 (Employees and their Dependents only) .......... 107
- EXCESS COVERAGE LIMITATION .............................................................. 108
- FILING FOR MEDICAL AND WEEKLY DISABILITY BENEFITS ............... 108
- CLAIM FILING AND PROCESSING PROCEDURES .................................... 109
  - Deadlines for Filing Claims ................................................................. 109
  - Incomplete Claims .................................................................................. 109
  - Pre-Service Claims ............................................................................... 109
  - All Other Claims .................................................................................... 110
  - Claim Denials ......................................................................................... 111
  - Claim Appeal Procedure ............................................................... 111
  - Applicable Time Frames for Deciding Claim Appeals ......................... 112
- CIRCUMSTANCES RESULTING IN DENIAL OR LOSS OF BENEFITS ....... 112
- TERMINATION OF COVERAGE .................................................................. 114
- EMPLOYEES .............................................................................................. 114
- DEPENDENTS ............................................................................................ 115
- RESCISSION OF COVERAGE ...................................................................... 115
- NOTIFICATION OBLIGATION ...................................................................... 117
  - Eligible Individuals must notify the Plan Administrator of any event or change in circumstance that affects .................................................... 117
- CERTIFICATE OF CREDITABLE COVERAGE .......................................... 117
- GENERAL PLAN PROVISIONS ................................................................. 118
- BENEFICIARIES ....................................................................................... 118
- PHYSICAL EXAMINATIONS ...................................................................... 118
- FREE CHOICE OF DOCTOR ....................................................................... 118

iv
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENETIC INFORMATION NONDISCRIMINATION ACT</td>
<td>118</td>
</tr>
<tr>
<td>GOVERNING LAW</td>
<td>118</td>
</tr>
<tr>
<td>SUBROGATION</td>
<td>118</td>
</tr>
<tr>
<td>Introduction</td>
<td>118</td>
</tr>
<tr>
<td>Subrogation and Reimbursement – Rules for the Plan</td>
<td>119</td>
</tr>
<tr>
<td>PLAN DISCONTINUANCE OR TERMINATION</td>
<td>121</td>
</tr>
<tr>
<td>RELEASE OF INFORMATION</td>
<td>122</td>
</tr>
<tr>
<td>SEVERABILITY CLAUSE</td>
<td>122</td>
</tr>
<tr>
<td>TRUSTEE INTERPRETATION, AUTHORITY, AND RIGHTS</td>
<td>122</td>
</tr>
<tr>
<td>WORKERS' COMPENSATION</td>
<td>123</td>
</tr>
<tr>
<td>COVERAGE UNDER ANOTHER HEALTH CARE PLAN</td>
<td>123</td>
</tr>
<tr>
<td>INFORMATION ABOUT THE PLAN</td>
<td>124</td>
</tr>
<tr>
<td>NAME OF PLAN/FUND</td>
<td>124</td>
</tr>
<tr>
<td>TYPE OF PLAN</td>
<td>124</td>
</tr>
<tr>
<td>PLAN SPONSORSHIP AND ADMINISTRATION</td>
<td>124</td>
</tr>
<tr>
<td>SERVICE OF LEGAL PROCESS</td>
<td>124</td>
</tr>
<tr>
<td>SOURCE OF CONTRIBUTIONS/PLAN PARTICIPATION</td>
<td>124</td>
</tr>
<tr>
<td>ACCUMULATION OF ASSETS/PAYMENT OF BENEFITS</td>
<td>125</td>
</tr>
<tr>
<td>PLAN YEAR</td>
<td>125</td>
</tr>
<tr>
<td>TRUST’S EMPLOYER IDENTIFICATION NUMBER &amp; PLAN NUMBER</td>
<td>125</td>
</tr>
<tr>
<td>UNION</td>
<td>125</td>
</tr>
<tr>
<td>ASSOCIATION</td>
<td>125</td>
</tr>
<tr>
<td>LIST OF EMPLOYERS AND EMPLOYEE ORGANIZATIONS</td>
<td>126</td>
</tr>
<tr>
<td>QUALIFIED MEDICAL CHILD SUPPORT PROCEDURES</td>
<td>126</td>
</tr>
<tr>
<td>PREFERRED PROVIDER NETWORK DIRECTORY</td>
<td>126</td>
</tr>
<tr>
<td>YOUR RIGHTS UNDER ERISA</td>
<td>127</td>
</tr>
<tr>
<td>RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS</td>
<td>127</td>
</tr>
<tr>
<td>CONTINUE GROUP HEALTH PLAN COVERAGE</td>
<td>127</td>
</tr>
<tr>
<td>PRUDENT ACTIONS BY PLAN FIDUCIARIES</td>
<td>128</td>
</tr>
<tr>
<td>ENFORCE YOUR RIGHTS</td>
<td>128</td>
</tr>
<tr>
<td>ASSISTANCE WITH YOUR QUESTIONS</td>
<td>128</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>129</td>
</tr>
<tr>
<td>MEDICAL DATA PRIVACY</td>
<td>149</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>149</td>
</tr>
<tr>
<td>THE PLAN’S USE AND DISCLOSURE PHI</td>
<td>149</td>
</tr>
<tr>
<td>USE OF PHI FOR TREATMENT PURPOSES</td>
<td>149</td>
</tr>
<tr>
<td>USE OF PHI FOR PAYMENT AND HEALTHCARE OPERATIONS</td>
<td>150</td>
</tr>
<tr>
<td>OTHER USES AND DISCLOSURES OF PHI</td>
<td>152</td>
</tr>
<tr>
<td>RELEASE OF PHI TO THE BOARD OF TRUSTEES</td>
<td>152</td>
</tr>
<tr>
<td>TRUSTEE ACCESS TO PHI FOR PLAN ADMINISTRATION FUNCTIONS</td>
<td>153</td>
</tr>
<tr>
<td>NONCOMPLIANCE ISSUES</td>
<td>153</td>
</tr>
<tr>
<td>PLAN’S PRIVACY OFFICER AND CONTACT INDIVIDUAL</td>
<td>153</td>
</tr>
<tr>
<td>HIPAA SECURITY</td>
<td>155</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>155</td>
</tr>
<tr>
<td>A. Policies to Protect Electronic PHI</td>
<td>155</td>
</tr>
<tr>
<td>B. Business Associates</td>
<td>155</td>
</tr>
</tbody>
</table>
C. Access to Electronic PHI for Plan Administrative Functions ................................. 155
D. If You Have Any Questions............................................................................. 156

PATIENT PROTECTION AND AFFORDABLE CARE ACT ........................................ 157
SUMMARY OF BENEFITS

SUMMARY

This Summary of Benefits provides you with a brief description of the limits that apply to each type of benefit provided by the Plan. Benefits are payable to Eligible Individuals only for services described in this document that are Medically Necessary and not otherwise excluded. More information about the benefits summarized here is provided in the later sections of this document.

This schedule describes the maximum amount payable for any benefits. Of course, the amount payable may be affected by the other provisions of this Plan, including the limitations provisions, and the description of the specific benefits payable under the Plan contained in each section.

PLAN MAXIMUMS

Lifetime Major Medical Maximum

The Plan will not pay more than $1,000,000 in major medical benefits other than Essential Health Benefits on behalf of any Eligible Individual.

Annual Maximum Benefit for Essential Health Benefits

The Plan will not pay more than $1,000,000 in benefits for Essential Health Benefits on behalf of any Eligible Individual during the Plan Years that begin on January 1, 2011, January 1, 2012, and January 1, 2013.

For Plan Years beginning on or after January 1, 2014, the law currently does not permit the Plan to impose an annual maximum benefit on Essential Health Benefit. However, should the law change such that the Plan may continue to impose an annual maximum benefit on Essential Health Benefit for Plan Years beginning on or after January 1, 2014, the Plan may impose an annual maximum benefit on Essential Health Benefits.

Major Medical Deductible* (See “Calendar Year Deductibles”)

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$200</td>
</tr>
<tr>
<td>Family</td>
<td>$600</td>
</tr>
</tbody>
</table>

Annual Out-Of-Pocket Maximum (see “Maximum Out-of-Pocket Expense”)

Major Medical Benefits*

The out-of-pocket maximum that you or your Beneficiaries must pay in a Calendar Year is $3,000 (above and beyond any deductible).
**Prescription Drug Benefits**

The out-of-pocket maximum that you or your Beneficiaries must pay in a Calendar Year for Prescription Drug Benefits is $1,000.

* **EMERGENCY ROOM CO-PAYMENT** – A $100 copayment applies to each emergency room visit and does not apply to the Calendar Year Deductible or the Annual Out-Of-Pocket Maximum.

**COVERAGE FOR THE EMPLOYEE ONLY**

**LIFE BENEFIT** - $15,000 (see “Life Benefit”)

**ACCIDENTAL DEATH AND DISMEMBERMENT** - $15,000 for loss of life, $7,500 or $15,000 depending upon severity of injuries for other covered losses - (See “Accidental Death and Dismemberment Benefit”)

**WEEKLY DISABILITY BENEFIT** - (See “Weekly Disability Benefit”)

- Maximum Period of Payment: Twenty-six (26) weeks
- Benefits start after either the first day following the disability if the disability was caused by Injury or the eighth (8th) day if caused by Sickness.

<table>
<thead>
<tr>
<th>Disability Due to Injury:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit Period</td>
</tr>
<tr>
<td>Twenty-six (26) weeks per disability</td>
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</tbody>
</table>

<table>
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<tr>
<th>Disability Due to Sickness:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit Period</td>
</tr>
<tr>
<td>Twenty-six (26) weeks per disability</td>
</tr>
</tbody>
</table>
COVERAGE FOR ALL ELIGIBLE INDIVIDUALS

Major Medical Benefits
The Plan will pay eighty (80%) percent of the Reasonable and Customary Charges for the following if they are Medically Necessary for the treatment of a covered Sickness or Injury.

HOSPITAL EXPENSE BENEFITS – See “Hospital Expense Benefit”.

TRANSPORTATION SERVICES – See “Transportation Services”.

PROPHYLACTIC MASTECTOMY BENEFIT - See “Prophylactic Mastectomy Benefit”.

CONVALESCENT FACILITY BENEFIT - See “Convalescent Facility Benefit”.

HOME HEALTH CARE BENEFIT - See “Home Health Care Benefit”.

HOSPICE CARE BENEFIT- See “Hospice Care Benefit”.

REPLACEMENT OF ORGANS AND TISSUE BENEFIT - See “Replacement of Organs and Tissue Benefit”.

DEVELOPMENTAL DELAY THERAPY SERVICES – See “Developmental Delay Therapy Services”.

OTHER MAJOR MEDICAL BENEFITS - See “Other Major Medical Benefits”.

MENTAL HEALTH EXPENSE BENEFIT - See “Mental Health Expense Benefit”.

Out-patient treatment is limited to one hundred thirty (130) hours of treatment incurred in a Calendar Year.

Maximum Limits for Major Medical Benefits
The Plan contains an annual maximum benefit or a lifetime maximum benefit for some of its major medical benefits. These limits include the following:

Medical Foods
$5,000 per Calendar Year

Chiropractic Care
$40 per visit and twenty-six (26) visits per Calendar Year
Lifetime Maximum for the nonsurgical treatment of TMJ
$1,500

Lifetime Maximum for gastric bypass surgery
$25,000

Charges for the treatment of infertility, including in vitro fertilization, subject to the following requirements and limitations:

1. All covered courses of treatment for infertility, including in vitro fertilization, must be pre-authorized by a case manager designated by the Plan. You must contact the Plan Administrator prior to undergoing such infertility treatments to be eligible for coverage under the Plan.

2. Charges for in vitro fertilization will be payable only when the patient suffers from infertility which cannot be surgically repaired.

3. This benefit does not include charges related to freezing one (1). Those charges are specifically excluded under the provisions of this Plan.

4. This benefit does not include charges incurred for the use of a surrogate mother regardless of whether the surrogate mother is an Eligible Individual and regardless of whether the charges otherwise would be considered Covered Expenses under this Plan. Those charges are specifically excluded under the provisions of this Plan.

5. The in vitro fertilization benefit is subject to a $5,000 lifetime maximum.

Hearing Aid Benefit

$2,500 over a five (5) year period, which begins January 1, 2006 and expires December 31, 2010. Thereafter, $2,500 for each subsequent five (5) year period (i.e., January 1, 2011 through December 31, 2015, etc). This benefit includes the acquisition, servicing, and maintenance of Hearing Aids.

Non-Major Medical Benefits

The following benefits are also covered by the Plan, but they are not covered under the Plan’s Major Medical Benefits provisions. See the provisions for each particular benefit for a description of its payment rules.

VISION BENEFIT - See “Vision Benefit.”

This benefit is not subject to any deductible or coinsurance maximum.

DENTAL BENEFITS - See “Dental Benefits.”
PRESCRIPTION DRUG BENEFITS – See “Prescription Drug Benefits.”

The Plan will pay ninety (90%) percent of Covered Expenses for generic prescription drugs and eighty (80%) percent of Covered Expenses for brand name prescription drugs. The coinsurance amount will never be less than $5 and will count only towards satisfying the out-of-pocket maximum for Prescription Drug Benefits, and is not subject to a deductible. The co-insurance amount described in this paragraph will not count towards satisfying any out-of-pocket maximum for Major Medical Benefits. To take advantage of the mail-order prescription drug benefit or to receive paper claim forms, contact MedCo Health Solutions Inc.


Maximum Limits for Non-Major Medical Benefits

The Plan contains an annual maximum benefit or a lifetime maximum benefit for some benefits. These limits are as follows:

Vision Benefit (See “Vision Benefit”)

The Plan will pay one hundred (100%) percent of vision expenses incurred by an Eligible Individual, up to a maximum of $500 in any two (2) consecutive Calendar Year period. This maximum dollar amount does not apply to eye examinations for Dependent children under nineteen (19) years of age.

Dental Benefit (See “Dental Benefit”)

The Plan will pay dental expenses incurred by an Eligible Individual up to a maximum of $2,400 in any two (2) consecutive Calendar Years, according to the Summary of Dental Benefits. This maximum dollar amount does not apply to the following Dental Benefits for Dependent children under age nineteen (19): (i) routine dental examinations; (ii) sealants; (iii) dental prophylaxis; and (iv) topical fluoride treatments.

High-Risk Insurance Pool Benefit (See “High-Risk Insurance Pool Benefit”)

The Plan will not pay more than $15,000 in High-Risk Insurance Pool benefits on behalf of any Eligible Individual in any Calendar Year.

ELIGIBLE INDIVIDUALS IN THE “SENIOR PLAN”

As an Eligible Individual in the “Senior Plan” (See “Retiree Benefits: The Senior Plan”), you are entitled to most of the medical benefits provided to all other Eligible Individuals under the Plan. In addition, you may elect to continue dental coverage, as provided under “Continued Eligibility While Retired.” Once you
elect dental coverage, you may only change your election as provided under the “Election of Dental Coverage” provisions on page 23. There are, however, a few exceptions where coverage for members in the “Senior Plan” is either excluded or provided at a reduced amount.

The following coverages are reduced under the “Senior Plan”:

- Life Benefit (for the former Employee only): $2,000
- Hearing Aid Benefit - Not available to Eligible Individuals in the “Senior Plan” sixty-five (65) years of age or older.
- Vision Benefit - Not available to Eligible Individuals in the “Senior Plan” sixty-five (65) years of age or older.

The following coverages are completely excluded under the “Senior Plan”:

- Weekly Disability Benefit
- Accidental Death and Dismemberment
ELIGIBILITY

SUMMARY

This section describes how you and your Dependents become eligible for benefits under the Plan, and the various ways you can maintain that eligibility.

Once you become eligible, you will continue to be covered if you satisfy the requirements of the Plan as described more fully in this section.

EMPLOYEES

Initial Eligibility

You may establish your initial eligibility for benefits under either the “Quarterly (Rolling Three Month) Rule” or the “Six Month Rule” as provided below. You may also only become initially eligible for coverage under the Plan under either rule through Employer Contributions.

Quarterly (Rolling Three Month) Rule

Under the Quarterly Rule, you will become Covered Under the Plan if during any rolling three (3) month (quarterly) period you accumulate three hundred forty-five (345) hours worked for a Contributing Employer for which Contributions were received by the Plan. Once you accumulate the required hours during the required period, you will be eligible for coverage for a period of three (3) calendar months beginning on the first day of the second calendar month following the month in which you accumulate the requisite hours.

In determining whether you have accumulated three hundred forty-five (345) hours, the Plan will look at the first three (3) months of the four (4) month period immediately preceding the month in which you seek coverage. The last month of the four (4) month period is considered a “Lag Month.” The Lag Month is the month immediately preceding the month in which you seek coverage under the Plan. Hours worked in the Lag Month are not considered in determining initial coverage under the Plan, but will be considered in determining coverage in later months.

FOR EXAMPLE: If you accumulate three hundred forty-five hours in the rolling three (3) month period of January, February and March, you will become eligible for coverage under the Plan on May 1st for the three (3) calendar month period of May, June and July. April is the Lag Month in the above scenario.
However, if you did not accumulate three hundred forty-five hours during the period January through March, but did so in February, March and April, then you will become eligible for coverage under the Plan on June 1st for the three (3) calendar month period of June, July, and August. May is the Lag Month in this scenario.

**Six Month Rule**

Under the Six Month Rule, you will become Covered Under the Plan if during any rolling six (6) month period you accumulate four hundred sixty (460) hours worked for a Contributing Employer for which Contributions were received by the Plan. Once you accumulate the required hours during the required period, you will become Covered Under the Plan for a period of three (3) calendar months beginning on the first day of the second calendar month following the month in which you accumulate the requisite four hundred sixty (460) hours.

In determining whether you have accumulated four hundred sixty (460) hours, the Plan will look at the first six (6) months of the seven (7) month period immediately preceding the month in which you seek coverage. The last month of the seven (7) month period is considered a “Lag Month”. Hours worked in the Lag Month are not considered in determining initial coverage under the Plan, but will be considered in determining coverage in later months.

**FOR EXAMPLE:** If you accumulate four hundred sixty (460) hours in the rolling six (6) month period of April through September, you will become eligible for coverage under the Plan on November 1st for the three (3) calendar month period of November, December and January. October is the Lag Month in this scenario.

The Six Month Rule applies only to initial eligibility. The Quarterly (Rolling Three Month) Rule is used to determine your continuing eligibility for coverage under the Plan.

**Continuing Eligibility**

Once you first become eligible under the through Employer Contributions, your eligibility will continue as long as you continue to accumulate at least three hundred forty-five (345) hours of Employer Contributions* every rolling three (3) month (quarterly) period.

In determining whether you will continue to be Covered Under the Plan, if the Plan will look at whether:

#1 You are credited with at least three hundred forty-five (345) hours of Employer Contributions for work performed in the first three (3) months of the four (4) month period immediately preceding the month in which you file a claim for benefits; or
You are credited with at least three hundred forty-five (345) hours of Employer Contributions for work performed in the first three (3) months of the five (5) month period immediately preceding the month in which you file a claim for benefits; or

You are credited with at least three hundred forty-five (345) hours of Employer Contributions for work performed in the first three (3) months of the six (6) month period immediately preceding the month in which you file a claim for benefits.

Please note, as the above rules imply, there are three (3) rolling quarter periods that can provide you continuing eligibility for any particular month.

FOR EXAMPLE: You can establish eligibility for the month of July by accumulating three hundred forty-five (345) hours of Employer Contributions during:

- **January through March.** You will become eligible for coverage under the Plan on May 1\(^{st}\) for the three (3) calendar month period of May, June and July. April is the Lag Month.

- **February through April.** You will become eligible for coverage under the Plan on June 1\(^{st}\) for the three (3) calendar month period of June, July and August. May is the Lag Month.

- **March through May.** You will become eligible for coverage under the Plan on July 1\(^{st}\) for the three (3) calendar month period of July, August and September. June is the Lag Month.

* As more fully set forth below, if you do not accumulate three hundred forty-five (345) hours of Employer Contributions as required to maintain your eligibility for coverage, you may be able to maintain continuing eligibility for coverage through the use of Supplemental Reserve Credits or Self Payments.

**Maintenance of Eligibility for Employees Receiving Disability Benefits**

If you are eligible to or are receiving accident and sickness benefits under this Plan, or if you are eligible to receive benefits under any worker’s compensation, occupational disease law, or no-fault automobile insurance policy, you will receive twenty-nine (29) hours of contribution credits for each week that you are entitled to or are drawing such benefits. In no case will this exceed one hundred fifteen (115) hours of contribution credits in a month. Any excess contribution credits (above one hundred fifteen (115) in a month) will be credited to you at the end of your disability.
These contribution credits will cease when the entitlement to benefits ceases, or if earlier, when you have received twenty-six (26) consecutive weeks of contribution credits under this provision.

**Supplemental Reserve Credits**

Hours worked and for which Contributions are received by the Plan in excess of one thousand seven hundred fifty (1,750) hours in a Calendar Year will be designated as **Supplemental Reserve Credits**. Supplemental Reserve Credits are excess Employer Contributions that were not used to maintain your eligibility for Plan benefits during a past period. They may be used to continue coverage during periods when you have not obtained enough Employer Contributions to maintain eligibility. The maximum amount of Supplemental Reserve Credits that may be accrued is one thousand eight hundred (1,800).

If your eligibility would cease due to insufficient Employer Contributions, the Plan will apply the minimum number of Supplemental Reserve Credits per month necessary to make up for the shortfall in Employer Contributions and provide continued coverage. If you do not have sufficient Supplemental Reserve Credits to maintain coverage, you may maintain coverage under the Plan’s Self-Payment or Continuation Coverage Under COBRA procedures described in this document.

**Self-Payment Procedures**

If your eligibility would cease due to insufficient Employer Contributions, and if you do not have sufficient Supplemental Reserve Credits to maintain coverage, you may elect to continue coverage either by making self-payments or through COBRA Continuation Coverage (see page 30 for the rules applying to Continuation Coverage Under COBRA). Once you have made your election between self-payment and COBRA Continuation Coverage, however, it cannot be changed.

If you elect to continue coverage by making self-payments, you will be required to make the minimum self-payment per month necessary to make up for the shortfall in Employer Contributions and provide continued coverage. The amount of your self-payment will be calculated by multiplying the applicable hourly contribution rate by the shortfall in Employer Contributions. You may continue coverage by making self-payments until you once again satisfy the Plan’s continuing eligibility rules, but you will not be allowed to make full or partial self-payments for a period lasting longer than eighteen (18) consecutive months.

Depending on your month-by-month work history, it is possible that a single month’s self-payment may be equal to more than one hundred fifteen (115) hours of Employer Contributions. However, in no case will your required self-payments over any three (3) month period exceed the equivalent of three hundred forty-five (345) hours of Employer Contributions.
Reinstatement of Eligibility
If you become ineligible for Plan benefits because you fail to make the required self-payment to maintain eligibility, you must satisfy the Plan’s continuing eligibility rules, in order to restore your eligibility for Plan benefits without self-payments. However, If you lose eligibility through active employment but then maintain coverage through COBRA Continuation Coverage, you will also need to satisfy the Plan’s initial eligibility rules in order to restore your eligibility for coverage without self-contributions for COBRA Continuation Coverage.

Termination of Eligibility and Cancellation of Supplemental Reserve Credits On Taking Certain Employment
If you stop working in a job classification for which Contributions must be made to the Plan, you will immediately become ineligible for Plan benefits, your Supplemental Reserve Credits will be cancelled (reduced to zero), and you will have no right to continue to be Covered Under The Plan (other than any right you may have under COBRA), if all of the following are true:

- You work for an employer or as an employer that is not obligated to contribute to the Plan;
- Your work is of a type for which Employers contribute to the Plan; and
- Employer Contributions for your work would be due to the Plan if you were working under a Collective Bargaining Agreement.

If your eligibility is terminated and your Supplemental Reserve Credits are cancelled, any period of time you were covered through Supplemental Reserve Credits after you last worked in employment for which your Employer contributed to the Plan will count as part of any Continuation Coverage Under COBRA to which you may be entitled.

If the Plan requests, you must provide to the Plan access to reasonable information for the purpose of verifying your employment. The information which the Plan may require for this purpose may include, but is not limited to: paycheck stubs, Internal Revenue Forms 1040 (with attachments), and release forms permitting the Plan to obtain information from your employer.

The Plan is entitled to request that you periodically:

- Certify to the Plan in writing on a form acceptable to the Plan that you are unemployed or, in the alternative,
- Provide information satisfactory to the Plan to enable the Plan to conclude that any employment is not of a type that would cause you to lose your eligibility and Supplemental Reserve Credits.
If you fail to respond to the Plan’s request for information or certification or provide an incomplete or inadequate response, the Plan may do one (1) or more of the following:

- Terminate your eligibility;
- Cancel your Supplemental Reserve Credits or;
- Withhold payment of benefits until you respond or provide a complete and adequate response.

The Plan will notify you in writing if it terminates your eligibility and cancels your Supplemental Reserve Credits.

Eligibility through Reciprocity

Employer contributions made on your behalf to a carpenter’s health plan other than this Plan can be transferred to this Plan if the Trustees have signed a reciprocity agreement with the other plan and you would have been eligible for coverage under this Plan if the contributions had been made to this Plan.

Contact the Plan Administrator to see if any work you are performing outside the jurisdiction of the Union is covered by a reciprocity agreement.

Classroom Contribution Credits for Apprentices

If you are indentured into an apprenticeship program under the Carpenters and Joiners Apprenticeship and Journeymen Training Trust Fund (the “Apprenticeship Program”), you may receive contribution credits for some of the hours you spend in the classroom (“Classroom Contribution Credits”). These Classroom Contribution Credits are limited by the following rules:

1. You may receive up to eighty (80) Classroom Contribution Credits in any calendar quarter. If you attend class for more than eighty (80) hours in a calendar quarter, your classroom hours in excess of eighty (80) will not be reserved or otherwise ever serve as Classroom Contribution Credits or count towards eligibility for coverage under the Plan.

2. You can receive an hour of Classroom Contribution Credit only for an hour of actual classroom attendance for related school instruction required by the applicable apprenticeship standards. No Classroom Contribution Credits will be granted for any other time, including travel time to and from class.

3. If you are not eligible to become, or to continue to be, Covered Under The Plan for a particular coverage month, but only because of a shortfall in hours worked in the relevant previous months, Classroom Contribution
Credits you earned in those previous months will automatically be applied to reduce the shortfall for the coverage month.

4. In any coverage month, Contributions relating to hours worked will be applied before Classroom Contribution Credits, if any, will be applied.

5. If you are eligible to become, or to continue to be, Covered Under The Plan for each coverage month corresponding to the month in which you earned a particular Classroom Contribution Credit without considering the Classroom Contribution Credit, you will forfeit that Classroom Contribution Credit at the start of the last corresponding coverage month.

6. A Classroom Contribution Credit will never be designated as a Supplemental Reserve Credit.

Opt-Out For Health Savings Account (HSA) Coverage

A Dependent of an Eligible Employee or Eligible Retiree may elect to opt-out of coverage under this Plan if they are eligible for a health plan offered by their employer that is a high deductible health plan with a Health Savings Account (HSA). The Dependent must complete a “Waiver of Coverage” form to opt-out of coverage under the Plan.

The Dependent and Eligible Employee or Eligible Retiree understands that by electing to opt-out of coverage under the Plan, the Dependent will:

1. Not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, dental benefits, accidental death and dismemberment benefits, extended coverage options under federal law, or retiree benefits.

2. Have no right or claim to any Contributions made to the Plan for the purposes of funding the Dependent’s eligibility for coverage.

3. Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the Dependent’s employer.

4. Have no right to return to coverage under the Plan until such time as HSA and high-deductible health plan coverage is lost, the Dependent otherwise meets the eligibility requirements of the Plan and provides written notice to the Trustees of the desire to once again become covered by the Plan.

The “Waiver of Coverage” form can be obtained from the Plan Administrator. The Dependent must indicate the date upon which the waiver of coverage will be effective.
APPRENTICESHIP TRAINING BENEFIT

If you are indentured into a scheduled apprenticeship training session under the Carpenters and Joiners Apprenticeship and Journeymen Training Trust Fund (the “Apprenticeship Program”) you may receive a benefit for attending the Apprenticeship Program training (“Apprenticeship Training Benefit”). This Apprenticeship Training Benefit is subject to the following rules:

1. You may receive a weekly benefit of an amount approved by the Trustees, for attendance of all scheduled hours of an Apprenticeship Program training session, subject to the following:
   a. The maximum apprenticeship training benefit amount will be reduced by one-fifth for each day that you arrive late or leave early for a scheduled day of Apprentice Program training.
   b. If you are absent from a day of scheduled Apprenticeship Program training you will not receive any apprentice training benefit for that scheduled training session.
   c. You may receive an Apprenticeship Training Benefit under this section up to a maximum of four (4) times in a Calendar Year.

2. You are eligible to receive an Apprenticeship Training Benefit only if at the time you attend your scheduled Apprenticeship Program training you:
   a. Are working for a Contributing Employer;
   b. Are not collecting unemployment compensation;
   c. Have not refused employment with a Contributing Employer or the referral hall;
   d. Are a member of the Union in good standing; and
   e. Have timely provided the contact information for your Employer required by the Plan or its designated representative.

COVERAGE FOR ALUMNI EMPLOYEES

If you satisfy the Plan’s definition of Alumni Employee, you will be entitled to Plan benefits if you satisfy the Plan’s initial and continuing eligibility requirements and your Employer has signed a Participation Agreement with the Trustees agreeing to make Employer Contributions to the Plan on your behalf. Contact the Plan Administrator if you have any questions about Alumni Employee coverage.
COVERAGE FOR YOUR DEPENDENTS AFTER YOUR DEATH

If you, the Employee, die while Covered Under The Plan, the coverage which was in force at the time of your death will be continued for your Dependents until any Supplemental Reserve Credits that you have are exhausted. After your Supplemental Reserve Credits are exhausted, coverage for your Dependents may be continued, so long as they make the required Self-Contributions.

Dependent coverage, including your spouse's, will stop on the date on which the earliest of the following occur:

1. Your spouse is remarried.

2. The Dependent ceases to meet this Plan’s definition of a Dependent, unless the Dependent is entitled to enroll and does enroll for continued coverage (refer to “Continuation Coverage Under COBRA” section in this document).

3. The last day of the Continuation Coverage Under COBRA period for which correct and on-time Self-Contributions have been made for Continuation Coverage Under COBRA, or the date of occurrence of any event stated in the “Continuation Coverage Under COBRA” section in this document which causes that coverage to terminate.

4. The Trustees’ discontinue Dependent coverage for the class of Employees you were in right before your death.

5. The end of the period for which Contributions have been made if required.

6. The Plan is terminated.

If your child is born after your death, that child may be covered as a Dependent during the period that your other Dependents are Covered Under The Plan.

ELIGIBILITY DURING PERIODS OF MILITARY SERVICE

You must inform the Plan Administrator in writing as soon as you know that you are entering military service.

- When a Dependent enters into military service, the Dependent’s coverage under the Plan will cease on the date the Dependent ceases to meet this Plan’s definition of Dependent because the Dependent becomes eligible for enrollment in a health plan established or maintained by the government of the United States or any state, including TRICARE.

- When an Employee enters into military service, the Employee may elect to discontinue (“freeze”) coverage or continue coverage (including coverage
for Dependents) under the Plan during military service. An Employee who elects to continue coverage may do so by using Supplemental Reserve Credits or by electing Military Continuation Coverage as described below.

**Freezing Coverage**

- Unless you and/or your Dependents choose Military Continuation Coverage as described below, coverage for you (the Employee) and your Dependents will cease on the date you enter military service. Your eligibility status will be "frozen" when you enter military service and will be fully restored when you return to work with a Contributing Employer (or are available for work for a Contributing Employer, but no such work is available). Please refer to the section entitled "Coverage Following Military Service" on page 17 for information about the time limits for returning to work.

**Military Continuation Coverage**

If you enter military service, you and/or your Dependents have the right to elect to continue coverage under the Plan. To continue coverage you have two options:

- First, you may continue coverage by using your Supplemental Reserve Credits. If you do not elect any other option, your coverage will be so continued until your Supplemental Reserve Credits are exhausted.

  If you use Supplemental Reserve Credits to continue coverage you may extend your coverage after your Supplemental Reserve Credits are fully used by electing COBRA Continuation Coverage (see page 30). You may make this election either at the time you are leaving for the military or at the time you exhaust your Supplemental Reserve Credits.

- Second, you may elect COBRA Continuation Coverage at the time you leave for the military and save your Supplemental Reserve Credits to use after you return from military service.

Under either option, your coverage will terminate on the earlier of: 1) the first day of the month for which your Supplemental Reserve Credits have been exhausted and a timely self-payment is not received, 2) for military leaves beginning prior to December 10, 2004, the end of eighteen (18) months of such continued coverage, 3) for military leave beginning on or after December 10, 2004, the end of twenty-four (24) months of such continued coverage, or 4) the day after the last date on which you are required to apply for or return to a position of employment with a Contributing Employer (see the chart titled “Time limits to return to work,” on page 18).
If you elect to use COBRA Continuation Coverage, the following rules apply:

- The Employee on military duty or Dependent who elects COBRA Continuation Coverage must timely remit the entire payment required to maintain coverage under the Plan on a self–pay basis as determined by the Trustees.

- Payment of the self-pay Contribution must be remitted to the Plan Administrator by the first day of each month. If a payment is not received within thirty (30) days of that date, coverage will be terminated back to the first of the month.

- All of the other rules pertaining to COBRA Continuation Coverage also apply (see page 30).

**Coverage Following Military Service**

If you elect to freeze coverage, your eligibility status is frozen when you enter military service provided you have notified the Plan Administrator of that service. Your coverage and that of your Dependents will cease when you enter the military. If you and your Dependents were eligible for coverage when you entered military service, you again will be covered when you return to work for an Employer in work covered by the Plan within the time limits described below.

If you elected to continue coverage through Supplemental Reserve Credits and COBRA Continuation Coverage and your coverage has run out while you were on military duty, you may, on returning to employment within the time limits described below, either become eligible again as a new Employee by working and having Contributions made (see “Initial Eligibility,” page 7) or by making payments to the Plan in the same amount as required for COBRA Continuation Coverage.

The time limits for returning to work are described below. If when you leave active duty, no work is available, but you have attempted to report and are available for work with an Employer: 1) if you froze your coverage it will be reinstated based on your Supplemental Reserve Credits, and 2) if you elected to continue coverage and it has run out, you may make self-payments to start your coverage again. The time limits provided below may be extended if you have suffered a service-connected Injury or Sickness. You should contact the Plan Administrator if that has occurred.
## Time limits to Return to Work or Report for work (If No Work is Available)

<table>
<thead>
<tr>
<th>If you were in military service</th>
<th>You must</th>
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<tbody>
<tr>
<td>1 to 30 days</td>
<td>Report to your Employer (or another Contributing Employer) by the beginning of the first regularly scheduled work day more than eight (8) hours after you return home.</td>
</tr>
<tr>
<td>31 to 180 days</td>
<td>Submit an application for reemployment to your Employer (or another Contributing Employer) within fourteen (14) days after the completion of your service.</td>
</tr>
<tr>
<td>More than 180 days</td>
<td>Submit an application for reemployment to your Employer (or another Contributing Employer) within ninety (90) days after the completion of your service.</td>
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</tbody>
</table>

If you do not return to work with the same Contributing Employer, you should notify your Local Union that you are available for work with a Contributing Employer.

### FAMILY AND MEDICAL LEAVE

Under the Family and Medical Leave Act of 1993 (the “FMLA”) and the National Defense Authorization Act of 2010 your Employer may be required to provide you with coverage under this Plan for up to twelve (12) weeks if you are away from work for a limited number of reasons. You will only be eligible for this protection if you are actively employed by a Contributing Employer that has fifty (50) or more Employees for at least one (1) year. In addition, you must have worked at least one thousand two hundred fifty (1,250) hours for that Employer over the previous twelve (12) months at the time that you wish to take FMLA leave.

### Advance Notice and Medical Certification

The Plan may require you to provide advanced notice and medical certification before FMLA leave is granted. Leave may be denied if the following requirements are not satisfied:

- You must provide the Plan with thirty (30) days advance notice of your intent to take FMLA leave when it is foreseeable; and;
- The Plan may require you to provide medical certification to support a request for leave due to a serious health condition.
Reasons for Taking FMLA Leave
You may be entitled to coverage under the FMLA if your leave is due to any of the following reasons:

- To care for your child after the birth or the placement of a child with you for adoption or foster care;
- To care for your spouse, child, foster child, adopted child, stepchild or parent who has a serious health condition;
- For a serious health condition that makes it impossible for you to perform your job duties;
- Military Care Giver Leave to care for a parent, spouse, child, or relative to whom the Employee is next of kin when the family member is a veteran who served in the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five (5) years before the date the veteran undergoes the medical treatment, recuperation or therapy;
- To care for a service member whose serious injury or illness was incurred before the active duty but was aggravated by military service in the line of active duty. For veterans, a serious illness or injury is a “qualifying injury or illness” that was incurred in the line of duty on active duty in the Armed Forces and that manifested itself before or after the service member became a veteran. Only where the serious injury or illness rises to the level of a subsequent injury or illness will an Employee be entitled to take leave for the same covered service member; or
- Qualifying Exigency Leave covers members of the regular Armed Forces who are deployed to a foreign country. For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country. For members of the Reserves, it means duty during deployment to a foreign country under a call or order to active duty pursuant to specified provisions of federal law. In order for an Employee to be covered under Qualifying Exigency Leave, the Employee’s spouse, son, daughter or parent must be on “covered active duty.”

Qualifying exigencies include:

1. Short-notice deployment;
2. Military events and related activities;
3. Childcare and school activities;
4. Financial and legal arrangements;
In the event that both you and your spouse are covered by this Plan, the continued coverage to care for a newborn or a child placed with you for adoption or foster care may not exceed a total of twelve (12) weeks.

**Failure to Return from FMLA**

If you do not return to active work after the approved FMLA leave; provide notice of your intent not to return while on leave, or if you exhaust the twelve (12) week FMLA leave period, you may continue coverage under COBRA. See the COBRA provisions starting on page 30 for more details.

**Contribution While Out on FMLA Leave**

If you are eligible for an FMLA leave, your Employer will continue to make Contributions to the Plan on your behalf while you are out on an FMLA related leave.

**State Family and Medical Leave Laws**

Many states, including Minnesota, also have laws governing family leave, which may give you additional rights. You should contact your Employer to learn more about these rights.

**FMLA Questions**

If you have questions regarding the FMLA, please contact your Employer.

**RETIREE BENEFITS: “THE SENIOR PLAN”**

*Retiree Benefits are not an “accrued” or “vested” benefit. That is, there is no guarantee that the benefits will continue into the future. Retiree Benefits may be changed, reduced, or eliminated at any time based on decisions made by the Trustees in their sole discretion.*

When you retire, there are two (2) ways of continuing your coverage for yourself and your Dependents:

**Continuation Coverage** is available up to eighteen (18) months for you and thirty-six (36) months for your Dependents, provided you make the correct Self-Contributions on time. Refer to "Continuation Coverage Under COBRA" in this document for more information. If you elect COBRA Continuation Coverage, you cannot be covered under the Retiree Benefits when this coverage ends.
Retiree Benefits are available for you and your Dependents as long as you satisfy the eligibility requirements and make the correct Self-Contributions on time.

CONTINUED ELIGIBILITY WHILE RETIRED

Within sixty (60) days of the date you cease to be Covered Under The Plan as an Employee, you may elect to continue coverage for yourself and your Dependents on a self-payment basis but only if:

- You are entitled to receive a disability pension from the Twin City Carpenters and Joiners Pension Plan, or
- You have retired, but only once you no longer have enough Supplemental Reserve Credits to pay for a month of coverage under the Plan and only if, upon retirement, you:
  - Were at least age fifty-five (55),
  - Had been eligible for Plan benefits (including eligibility through Self-Contributions) for at least thirty-six (36) of the previous sixty (60) months, and
  - Had been credited with at least five (5) years of service (as defined in the Twin City Carpenters and Joiners Pension Plan).

For this purpose, you are considered retired once you are no longer doing work that would subject a monthly retirement benefit under the Twin City Carpenters and Joiners Pension Plan to suspension.

If you elect to participate in the “Senior Plan” and then return to work, your benefits may be subject to suspension. Specifically, if you engage in any Disqualifying Employment, your benefits may be suspended. “Disqualifying Employment” is:

1. Any employment that would cause suspension of a participant in the Twin City Carpenters and Joiners Pension Plan’s retirement benefit; or

2. Any employment of more than forty (40) hours in a month in covered employment; or

3. Any work of more than forty (40) hours in a month for any employer, or on a self-employed basis, anywhere in the United States, in the industry
covered by the United Brotherhood of Carpenters and Joiners Collective Bargaining Agreements, which work includes, but will not be limited to:

a. Work in the occupation for which you were employed while accruing benefits under the Plan;

b. Work at any position or occupation substantially involving the tools of the construction trades (except as it relates to retail sales positions);

c. Work as described in a United Brotherhood of Carpenters and Joiners Collective Bargaining Agreement;

d. Work for any construction company or self-employment in the construction industry;

e. Post secondary teaching or instructing which involves the construction industry;

f. Consulting or managing work on projects in which the construction industry is involved;

g. Inspector positions;

h. Estimator positions; and

i. Any other employment that involves either the use of the tools or skills learned while working in the carpentry trade or the construction industry, except primary and secondary teaching.

If you elect to participate in the “Senior Plan” and then return to work that would result in the suspension of your monthly retirement benefit under the above noted rules:

- If the employer you go to work for is not a Contributing Employer to this Plan, you will be immediately and permanently disqualified from participating in the “Senior Plan.”

- If the employer you go to work for is a Contributing Employer to this Plan, (1) you will be permitted to continue participating in the “Senior Plan” (but only until you again become eligible under the Plan as an active employee), (2) Employer Contributions received on your behalf will be used to pay for your premiums as an active employee, and (3) you will have the chance to re-qualify for the “Senior Plan” once you re-retire.
Election of Dental Coverage
You will remain eligible to receive dental coverage while retired as long as you maintain continuous coverage on the date you retire. The “Senior Plan” gives you the option of continuing to receive dental benefits from the Plan.

If you elect to continue the Plan’s dental coverage (described in the Dental Benefits section of this document), the dental coverage will remain in effect for the entire time that you and your Dependents remain covered under the “Senior Plan”, unless you exercise the opt-out provision discussed below. The failure to self-pay for dental coverage that you have elected will constitute a failure to pay a required premium and will result in the termination of all coverage under the “Senior Plan”.

Opting Out of Dental Coverage under the “Senior Plan”
The Plan provides an annual opt-out period in which you may opt out of dental coverage under the “Senior Plan” following your initial election of coverage. This annual “opt-out period” runs from November 1 to November 30. To exercise this opt-out provision, you must complete the following steps:

1. Request an opt-out application form from the Plan Administrator at any point before or during the opt-out period.

2. Complete the opt-out application form and provide your completed form to the Plan Administrator at any point between the first and last days of the opt-out period. Provided you have submitted to the Plan Administrator a completed opt-out application form before the expiration of the opt-out period, dental coverage for you and your Eligible Dependents will terminate on January 1 of the following Plan Year.

Once you opt-out of dental coverage under the “Senior Plan”, you and your Eligible Dependents will not be permitted to re-elect dental coverage at any time in the future.

Contact the Plan Administrator for more information about dental coverage under the “Senior Plan”.

Coverage for Eligible Dependents
If you elect to enroll in the “Senior Plan”:

- All of your Eligible Dependents will be covered as long as you remain eligible to participate in the Plan and submit timely Self-Contributions, unless your spouse opts-out of coverage under the Plan’s “Opting Out of Coverage under the ‘Senior Plan’” provisions described below.

- You will not have the right to exclude any of your eligible Dependents from coverage.
If you decline to enroll in the “Senior Plan”, your eligible Dependents may elect COBRA Continuation Coverage.

If you die while Covered Under The Senior Plan, your eligible Dependents may maintain coverage under the Plan’s “Coverage for Surviving Dependents of Retirees” provisions, described below.

If you die before enrolling in the “Senior Plan”, but at the time of your death you had either: 1) already satisfied all of the requirements to be eligible for the “Senior Plan”, or 2) but for your death would have satisfied all of the requirements before your Supplemental Reserve Credits are exhausted, your surviving Spouse may enroll in the “Senior Plan” at the time you would have been entitled to do so.

**Payment of Self-Contributions for Retiree Benefits**

To ensure maximum benefits under the “Senior Plan”, you should follow these rules for the payment of Self-Contributions:

- The amount of the monthly Self- Contribution is determined by the Trustees and in their sole discretion may be changed at any time. You will be entitled to a discount as indicated below. For individuals who enroll in the “Senior Plan” on or after March 1, 2004, the discount is equal to a percentage of the required monthly Self- Contribution amount otherwise due and is based on Years of Service. For this purpose, “Years of Service” include: (1) Years of Service as defined in the Twin City Carpenters and Joiners Pension Plan, (2) years of membership with a local affiliate of the North Central States Regional Council of Carpenters (previously Lakes and Plains Regional Council of Carpenters and Joiners) before you entered this Plan, and (3) years of membership with Local Union 1313 (Mason City, Iowa) of the Heartland Regional Council of Carpenters before you entered this Plan.

<table>
<thead>
<tr>
<th>Years of Service*</th>
<th>Discount Rate</th>
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<tbody>
<tr>
<td>9 or fewer</td>
<td>0% (no discount)</td>
</tr>
<tr>
<td>10</td>
<td>10%</td>
</tr>
<tr>
<td>11 or more</td>
<td>10%, plus 2% for each year of service above 10 Years of Service</td>
</tr>
</tbody>
</table>

* If you first entered the Plan because of a merger with another plan under which you were covered and if you remained covered under the Plan after the merger, the Plan will give credit for your last continuous period of employment prior to the merger, based on rules established by the Trustees, provided there are adequate records to verify your service.
In no event will the discount exceed fifty (50%) percent. For an individual enrolled in the “Senior Plan” before March 1, 2004, the discount rate will be fifty (50%) regardless of Years of Service. If such an individual again becomes eligible under the Plan as an active employee, however, the individual permanently forfeits this default fifty (50%) percent discount rate, and any future discount rate the individual might enjoy will be based on Years of Service.

- Your initial monthly Self-Contribuition is due immediately when the Plan Administrator receives your “Senior Plan” election form. If that Contribution does not accompany the election form, the election form will be completely disregarded.

- The due date for all subsequent monthly Self-Contributions is the first day of the month in which coverage is to be provided. For example, payment for January coverage is due on or before January 1.

- A monthly Self-Contribuition will be considered to have been made on time only if the full payment is received by the due date.

- If a monthly Self-Contribuition is not made by the due date and coverage terminates for all affected individuals, the overdue payment may not be made up nor may coverage be reinstated by the making of further payments.

- Notices of due Self-Contributions will not be sent to retirees or their Dependents by the Plan Administrator.

- If you desire to have Self-Contributions to this Plan paid out of your benefit payments from the Twin City Carpenters and Joiners Pension Plan, you should contact the Plan Administrator at (952) 854-0795 or (800) 535-6373 for more information about this option.

### Opting out of Coverage under the Senior Plan

If you meet the eligibility requirements for retirement coverage and you and your spouse are covered by the Plan, you and/or your spouse may exercise an opt-out provision if you and/or your spouse have other coverage available through your spouse.

If you and/or your spouse exercise this opt-out provision, the following steps must be completed:

- Provide the Plan Administrator with documentation of the other health insurance coverage showing the effective date of that coverage and the names of those enrolled in the other coverage;
Complete and provide to the Plan Administrator an opt-out application form. Once you have provided the Plan Administrator with an opt-out application form, the earliest possible effective date of the opt-out will be the 1st of the month following thirty (30) days of the Plan Administrator’s receipt of the application form and other required documentation as described above.

You and/or your Eligible Dependents, including your spouse, will be permitted to re-enroll in the Plan within thirty (30) days of any of the following qualifying events by providing the Plan Administrator with documentation of the qualifying event:

- Your spouse loses coverage through retirement, termination of employment (voluntary or involuntary) or reduction in hours; or
- A significant increase in the cost you pay (defined as an increase of fifty (50%) percent or more per month) for coverage available through a spouse; or
- You are no longer eligible as a dependent under your spouse’s plan due to divorce or legal separation (in which case you may re-enroll yourself only).

To continue eligibility for coverage in the Plan, you and your spouse must each re-enroll in the Plan upon becoming Medicare eligible; however, if your spouse continues to be covered as an active employee in his or her employer’s plan, you and/or your spouse may defer re-enrollment until your spouse retires or experiences another qualifying event. If you and your spouse do not re-enroll in the Plan within thirty (30) days of your spouse’s retirement and loss of coverage, you and your spouse will lose eligibility for the coverage under the Plan permanently.

**EXAMPLES**

A Retiree and spouse opt-out of the Plan because the spouse has coverage through the spouse’s employer:

- If the spouse loses coverage due to retirement, termination of employment or reduction in hours, the Retiree and spouse may both re-enroll in the Plan within thirty (30) days of the loss of coverage.
- If the spouse regains access to coverage through an employer, the Retiree and spouse may again exercise the opt-out provision, subject to the same reentry requirements.
If the Retiree and spouse do not re-enroll within thirty (30) days of the loss of coverage, the Retiree and spouse may not re-enroll in the Plan at any time in the future.

A spouse opts-out of the Plan because the spouse has coverage through his or her employer:

- If the spouse loses coverage due to retirement, termination of employment or reduction in hours, the spouse may re-enroll in the Plan within thirty (30) days of the loss of coverage.
- If the spouse regains access to coverage through an employer, the spouse may again exercise the opt-out provision, subject to the same reentry requirements.
- If the spouse does not re-enroll within thirty (30) days of the loss of coverage, the spouse may not re-enroll in the Plan at any time in the future.

If a Retiree and spouse cancel their coverage through the Plan and do not have other coverage, they will not be permitted to re-enroll in the Plan at any time in the future.

If a Retiree and spouse opt-out of the Plan and the Retiree dies, the spouse will not be permitted to re-enroll in the Plan at any time in the future.

Retirees who reenter the Plan after exercising the opt-out provision will be subject to the rate discount (based on retirement date and/or Years of Service) in place prior to opting out.

**Coverage through the Veteran’s Administration**

If you meet the eligibility requirements for retirement coverage, you or your spouse may exercise a one-time opt-out provision if you or your spouse has other coverage available through the Veteran’s Administration.

- If you are covered through the Veteran’s Administration, you will be permitted to maintain coverage for your spouse and/or Dependent child(ren).
- If your spouse has coverage through the Veteran’s Administration, you may stay on the Plan with single coverage or Dependent child(ren) coverage.

A Retired Employee or spouse with coverage through the Veteran’s Administration will not be permitted to opt back in to the Plan for any reason except attainment of Medicare
eligibility. The Retired Employee or spouse with coverage through the Veteran's Administration must re-enroll in the Plan within thirty (30) days of attaining Medicare eligibility. Upon opting back in to the Senior Plan, you or your spouse will not be permitted to re-enroll if you leave the Plan again for any reason.

**Coverage for Surviving Dependents of Retirees**

Your surviving Dependents may continue their coverage based on your status in the Plan at the time of your death if:

- **You were making Self-Contributions for Retiree Benefits.**
  
  Your surviving spouse can continue to pay Self-Contributions for all eligible family members. Coverage will continue as long as the correct Self-Contributions are paid on time or until he or she remarries or dies, whichever occurs first. Coverage may end earlier. Refer to the next section for more details.

- **You were making Self-Contributions for Continuation Coverage Under COBRA.**
  
  Your surviving Dependents may continue coverage by paying Self-Contributions up to thirty-six (36) months, minus the number of Self-Contributions already paid by you. If your surviving spouse should die during the time when Self-Contributions have been paid, the children (or their guardian) may continue to pay the Self-Contributions up to thirty-six (36) months, minus the number of Self-Contributions already paid by you or your spouse.

  If your surviving Dependents don't elect to make Continuation Coverage Self-Contributions when you die, they will not be permitted to make Self-Contributions at any future date.

- **You were eligible for Retiree Benefits and either there was no surviving spouse or the spouse died.**
  
  Your eligible children or a legal guardian can pay the Self-Contributions for the surviving Dependent children. Coverage will continue as long as the Dependent remains eligible and the correct self contributions are paid on time, unless coverage ends earlier. Refer to the next section for more information.

**Termination of Coverage for Retirees and Their Dependents**

Coverage under the Plan for Retirees will end on the earliest of the following dates:

- The date the Trustees terminate this Plan;

- The date the Trustees terminate Plan benefits for Retirees or a class of Retirees in which you are included;
The Carpenters and Joiners Welfare Fund

Eligibility

- The last day of the benefit month preceding the benefit month for which you do not make a proper and on-time Self- Contribution; or
- The date of your death.

Coverage under the Plan for your Dependent(s) will end on the earliest of the following dates:

- The date the Trustees terminate this Plan;
- The date the Trustees terminate Plan benefits for Retirees or a class of Retirees in which you are included;
- The date the Trustees terminate Dependent Benefits under this Plan;
- The date the Dependent becomes eligible for enrollment in a health plan established or maintained by the government of the United States or any state, including TRICARE;
- The date the Dependent becomes eligible under this Plan as an Employee;
- The date on which the Retiree's eligibility for Plan coverage terminates;
- The date the Dependent ceases to meet this Plan's definition of a Dependent, unless the Dependent is entitled to enroll and does enroll for COBRA Continuation Coverage (refer to "Continuation Coverage Under COBRA" section in this document); or
- The last day of the Continuation Coverage period for which correct and on-time Self- Contributions have been made for COBRA Continuation Coverage, or the date of occurrence of any event stated in the "Continuation Coverage Under COBRA" section in this document which causes that coverage to terminate.

If you die while making Self- Contributions for Retiree Benefits, Dependent coverage will end:

1. At the end of the last day of the last benefit month for which you had made a Self- Contribution before your death, unless your Dependent elects to continue coverage and Self- Contributions are made by or on behalf of the Dependent;
2. When the COBRA Continuation Coverage maximum period ends for your spouse or any Dependent children;
3. On the date when a correct and on-time Self-Contribution fails to be made by or on behalf of the Dependent;

4. On the date the Dependent fails to meet the definition of a Dependent; or

5. For the surviving spouse, on the date the surviving spouse remarries or dies, whichever occurs first.

**CONTINUING ELIGIBILITY THROUGH SELF-CONTRIBUTIONS (“CONTINUATION COVERAGE UNDER COBRA”)**

If you lose your job, you can make Self-Contributions to continue your coverage. Your Dependents can also make Self-Contributions if they are going to lose coverage for certain reasons as explained below.

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as COBRA) gives you and your Dependents the right to be offered an opportunity to make Self-Contributions for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "Continuation Coverage." The following is an outline of the rules governing Continuation Coverage. If you have any questions about this coverage, call the Plan Administrator's office.

Please note that additional or alternative coverage (other than Continuation Coverage) may be available to Retired Employees, to spouses, and to other Dependents. Those types of coverage are described elsewhere in this Eligibility section.

**Qualifying Events**

- You are entitled to elect Continuation Coverage and to make Self-Contributions for the coverage for up to eighteen (18) months after coverage terminates if coverage terminates due to one (1) of the following events (called "qualifying events"):  
  1. A reduction in your hours; or
  2. Your loss of employment (which includes retirement), except for termination of employment due to gross misconduct.

- In addition, your Dependents are entitled to elect Continuation Coverage and to make Self-Contributions for the coverage for up to thirty-six (36) months after coverage terminates if their coverage terminates due to one (1) of the following events (called "qualifying events"):  
  1. Your divorce or legal separation from your spouse;
2. A child's failure to meet the Plan's definition of a Dependent;
3. Your death; or
4. Your becoming enrolled in Medicare.

Weekly Disability Income Benefits are NOT provided under Continuation Coverage.

Notification Responsibilities

- You, your spouse, or your Dependent child must notify the Plan Administrator if you get divorced or legally separated or if a child loses Dependent status. The Plan Administrator must be notified within sixty (60) days of the date of any of these qualifying events or within sixty (60) days of the date coverage for the affected individual(s) would terminate, whichever date is later. In providing notice, you must provide documentation to support the qualifying event. In case of a divorce, a copy of the divorce decree or similar document evidencing the date of divorce (or legal separation) will be required. In case of Dependent losing Dependent status, documentation indicating the date Dependent status ended will be required.

- It is your Employer's responsibility to notify the Plan Administrator of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a Dependent should also notify the Plan Administrator any time any type of qualifying event occurs or any time your address changes.

- You must notify the Plan Administrator within sixty (60) days of the date of a disability determination from the Social Security Administration and within the first eighteen (18) months of COBRA coverage in order for you, your spouse, or your Dependent child who is or becomes disabled to become eligible for an additional eleven (11) months of coverage (a total of twenty-nine (29) months) which is available to disabled individuals (as explained below). In providing notice, you must provide a copy of the Social Security Administration determination of disability status.

Maximum Coverage Period

Eighteen (18) months is the maximum period of time that you (the Employee), your spouse, and Dependents can have Continuation Coverage if the Continuation Coverage is the result of your termination or reduction in hours of employment. For you, this maximum period can only be extended in a disability situation, as described below. For your spouse and Dependents, the maximum period can be extended for up to a maximum of twenty-nine (29) months in a disability situation or to a maximum of thirty-six (36) months if one (1) or more new qualifying event occurs while covered under
Continuation Coverage. For purposes of this section, "disabled" means becoming entitled to disability benefits under the Social Security Act.

Thirty-six (36) months is the maximum period of time that your spouse and Dependents can have Continuation Coverage if a qualifying event occurs, other than a termination or reduction in hours of employment. Thirty-six (36) months is also the maximum period of time that your spouse and Dependents can have Continuation Coverage even if one (1) or more new qualifying events occur to the individual while covered under Continuation Coverage.

For example, suppose that your death occurs while you are making Self-Contributions for Continuation Coverage because of reduced hours. You and your family had been covered under Continuation Coverage for six (6) months before your death. Because your death is a qualifying event for your Dependents, your spouse may and does elect to continue coverage by making Self-Contributions for himself or herself and your Dependent children. Your spouse is entitled to continue coverage for himself or herself and the children for an additional thirty (30) months (the maximum coverage period of thirty-six (36) months minus the number of Self-Contributions you had already made (36 - 6 = 30).

Then, after your spouse has continued coverage for fifteen (15) of the remaining thirty (30) months for himself or herself and the children, one of the Dependent children loses Dependent status. This is a qualifying event for the child entitling him or her to make Self-Contributions for Continuation Coverage for himself or herself. However, the thirty-six (3) month maximum coverage period is reduced by the twenty-one (21) months of Continuation Coverage already received (six (6) months from your Self-Contributions before your death plus fifteen (15) months from your spouse's Self-Contributions). The child is, therefore, entitled to make Self-Contributions for Continuation Coverage for up to fifteen (15) months (36 - 21 = 15).

If you, your spouse, or a Dependent are disabled when you elect this coverage or become disabled within the first sixty (60) days after you elect to continue coverage under COBRA, it may be extended from eighteen (18) to twenty-nine (29) months.

**Self-Contributions Procedures and Rules**

- When the Plan Administrator is notified of a qualifying event, an Election Notice will be sent to you and/or your Dependent(s) who would lose coverage due to the event. The Election Notice tells you about the right to elect Continuation Coverage, the due dates for payments, the benefit options that can be elected, the amount of the monthly Self-Contributions for each option, and other important information.
An Election Form will be sent along with the Election Notice. This is the form you or a Dependent must complete and send back to the Plan Administrator in order to elect Continuation Coverage.

The individual electing Continuation Coverage has sixty (60) days after he or she has been sent the Election Notice or sixty (60) days after coverage would terminate, whichever is later, to send back the completed Election Form. (However, it is strongly recommended that the form be sent back as soon as possible.) An election of Continuation Coverage is considered to be made on the date the Election Form is postmarked.

If the Plan Administrator is not notified of the Continuation Coverage Election within the allowable period, you and/or your Dependents will be considered to have waived your right to Continuation Coverage.

An individual electing Continuation Coverage has forty-five (45) days after the signed Election Form is returned to make his or her initial payment. (However, it is strongly recommended that the payment be made as soon as possible so that a number of months will not have to be paid for all at once.) The initial payment must be sufficient to pay all current and past due Contributions.

Continuation Coverage Self-Contributions must be made monthly. After the initial Self-Contributions, each subsequent monthly Self-Contributions is due by the first (1st) day of the benefit month for which the Self-Contributions are being made (the “due date”). A Self-Contributions will be considered on time if it is received by the Plan Administrator within thirty (30) days of the due date.

If a Self-Contributions is not made in the correct amount within the time allowed, Continuation Coverage for all affected family members will terminate. The Self-Contributions may not be made up nor may coverage be reinstated by making future Self-Contributions.

Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of Continuation Coverage.

If you elect Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents unless they make a separate election.

An election on behalf of your minor child can be made by you or another parent or legal guardian.
The amounts of the monthly Self-Contributions are determined by the Trustees based on Federal regulations. The amounts are subject to change but usually not more often than once a year unless substantial changes are made in the benefits provided to Eligible Individuals and Beneficiaries.

Special Enrollment Events

Notwithstanding any other provision of the Plan to the contrary, effective April 1, 2009, you or your Dependent(s) is entitled to special enrollment rights under the Plan as required by HIPAA under either of the following circumstances:

1. You or your Dependent’s coverage under a Medicaid Plan or under a state children’s health insurance program is terminated as a result of loss of eligibility for such coverage and you request coverage under the Plan not later than sixty (60) days after the date of termination of such coverage.

2. You or your Dependent become eligible for a state premium assistance subsidy from a Medicaid Plan or through a state children’s health insurance program, with respect to coverage under the Plan not later than sixty (60) days after the date you or your Dependent is determined to be eligible for such assistance.

Termination of Continuation Coverage

Continuation Coverage for an individual will be terminated before the end of the maximum coverage period when the first of the following events occurs:

1. A correct and on-time Self- Contribution is not made to the Plan;

2. The Plan no longer provides group health coverage to any Employees;

3. After the COBRA election date, the individual first becomes covered under another group health insurance plan with no pre-existing condition limitation or a limitation provision that does not apply to the individual or which the individual in question satisfies; or

4. After the COBRA election date, the individual becomes covered by Medicare.
LIFE BENEFIT

SUMMARY

The Plan provides a benefit to your designated Beneficiary in the event of your death if you are covered under this portion of the Plan. To designate or change a Beneficiary, contact the Plan Administrator.

You have the right to name a Beneficiary to receive any benefits in the event of your death. To do so, or to change that designation, contact the Plan Administrator.

If you (the Employee) suffer accidental death or the accidental loss of your sight or one or more limbs, the Plan also pays an additional benefit which is described in the section entitled, "Accidental Death and Dismemberment Benefit."

There are several limitations to the payment of this Life Benefit. They are described in this section.

The Plan will pay a Life Benefit (in the amount of $15,000 if you are an active employee or $2,000 if you are participating in the "Senior Plan") if you die from most causes while Covered Under The Plan. See the “Limitations” section, below, for a listing of Plan limitations on the Life Benefit. A proper application is required before any benefits will be paid. If you intend to designate a minor as your Beneficiary, a proper application includes information about the minor's guardian or the trust from which payments will be made.

If your death is accidental, your Beneficiaries will also receive an additional Accidental Death and Dismemberment Benefit, with the exception of Retirees as reflected on page 38.

BENEFICIARY

At the time of enrollment, you must complete a form naming one (1) or more primary Beneficiaries or alternative Beneficiaries. A Beneficiary designation will not be effective unless the designation includes the name, Social Security number, and address of the Beneficiary, as well as a description of the Beneficiary's relationship to you. If you name two (2) or more individuals as primary Beneficiaries, the benefit will be shared equally by any of them that survive you, unless otherwise specified. If none of the primary Beneficiaries survive you, the benefit will be shared equally by any alternative Beneficiaries that survive you, unless otherwise specified. You may change any Beneficiary designation from time to time without providing notice to any Beneficiary or getting the consent of any Beneficiary.
It is important to keep your Beneficiary information up to date. If, for example, there is a change in your marital status or the birth of a child, you may wish to complete a Change of Beneficiary Form. Also keep in mind that a Beneficiary designation becomes immediately ineffective if the indicated relationship ends because of a judgment and decree of marital dissolution. For example, the designation of a Beneficiary labeled as your “Spouse” becomes ineffective upon divorce.

If you fail to designate a Beneficiary, or you revoke a Beneficiary designation without naming another Beneficiary, or none of your designated Beneficiaries survives you, this Life Benefit (or the part of it with no valid designated Beneficiary) will be payable to individuals in the following order:

- Your Surviving Spouse
- Your Surviving Children (as provided below)
- The representative of your Estate

The term “Children” includes legally adopted children and illegitimate children. If the benefit is payable to your Children, they split the benefit equally. If one (1) of your Children has died before you do, that child’s surviving Children equally split any Life Benefit that would have gone to the deceased child had the deceased child survived you.

If you designate a minor child as your Beneficiary, you must provide the Plan Administrator with information regarding the child’s guardian or about the trust from which the payment of benefits will be made.

**TOTAL DISABILITY**

If you: 1) become Permanently and Totally Disabled before you reach age sixty (60); 2) cannot work for pay or profit; and 3) furnish all information, notices, and proofs when required, the amount of your Life Benefit may be extended during the total disability. This extension will depend on the status of your Life Benefit under the Plan when you: 1) become totally disabled; 2) the circumstances, nature, duration and proof of your disability; and 3) a physical examination, if required. You should report any Permanent and Total Disability immediately to the Plan Administrator to determine whether you qualify for this valuable extended coverage and the amount of coverage which may be continued. The Plan Administrator must receive written notice of claim for this extension within twelve (12) months after your covered employment ceases.

For purposes of this provision, “Permanent and Total Disability” is a total disability that exists continuously for at least six (6) months or to the date of death, if sooner.
LIMITATIONS

The Life Benefit will not be payable for any loss caused by or resulting from:

- Your death due to an accident occurring as a result of the reasons stated in paragraphs 26 and 48 of the “Plan Conditions, Limitations and Exclusions” section of this document.

- Your death due to suicide, unless the suicide results from a medical condition.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

SUMMARY

If you (the Employee) suffer accidental death or accidental loss of your sight or one or more limbs, the Plan will pay a benefit as set forth in this section. This benefit is payable regardless of whether the accident occurs during the course of your employment. You have the right to name a Beneficiary to receive any benefits in the event of your death. To do so or to change that designation, contact the Plan Administrator.

No benefits will be paid for injuries or death that occur due to any of the limitations described in the Plan’s “Life Benefit” provisions or for any intentionally self-inflicted Injury (unless the self-inflicted Injury results from a medical condition).

In the case of your accidental death, your Beneficiaries will also receive the Life Benefit, described in this document. Benefits for loss of life will be payable to your Beneficiary or Beneficiaries. All other Accidental and Dismemberment (“AD&D”) benefits will be paid directly to you.

Upon receipt of a proper application, the Plan will pay an AD&D benefit in the amount shown on the following chart if you suffer any of the listed bodily Injuries that are caused by an accident while you are Covered Under The Plan, and within twelve (12) months after the date of the accident.

BENEFITS

The amount of the payment for covered Injuries is based upon the severity of the Injury that you suffer. Please refer to the following chart for a description of the amount payable for each covered loss:

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Amount of Benefit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$15,000</td>
</tr>
<tr>
<td>Both Hands or Both Feet or</td>
<td></td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
<td>$15,000</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>$15,000</td>
</tr>
<tr>
<td>One Foot and Sight of One Eye</td>
<td>$15,000</td>
</tr>
<tr>
<td>One Hand and Sight of One Eye</td>
<td>$15,000</td>
</tr>
<tr>
<td>One Eye or the Sight of One Eye</td>
<td>$15,000</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
<td>$7,500</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>$7,500</td>
</tr>
</tbody>
</table>
BENEFICIARY

These benefits will be paid to the same Beneficiary that you designated under the Plan’s Life Benefit. Benefits for loss of life will be payable to the Beneficiary or Beneficiaries. All other AD&D benefits will be paid directly to you.
WEEKLY DISABILITY BENEFIT

SUMMARY

The Plan provides specific benefits ("loss-of-time benefits") if an Employee becomes Totally Disabled at a time when he or she is otherwise covered by this Plan. The requirements to receive those benefits are set forth in this section of the document.

If you (the Employee) have been disabled, contact the Plan Administrator to determine if you are eligible for this valuable benefit. This benefit is available only to active Employees.

ELIGIBILITY FOR BENEFITS

To be eligible for Weekly Disability Benefits, you must meet all of the following requirements:

- You must be Totally Disabled as a result of an Injury or Sickness and must satisfy the Plan's definition of Total Disability;
- You must have been Covered Under The Plan as an Eligible Employee due, at least in part, to Employer Contributions or the application of Supplemental Reserve Credits, on the date that you first satisfy the Plan’s definition of Total Disability;
- You must be under the care of a Physician for the Total Disability, and;
- You are not receiving salary, wages, unemployment compensation, or any retirement benefits.

INDEMNITY LIMITS AND BENEFIT PROVISIONS

- Benefits will be payable in an amount not to exceed the Maximum Weekly Disability Benefit specified on the Summary of Benefits.
- Benefits will be payable for up to but not exceeding the maximum indemnity benefit period of twenty-six (26) weeks during any one (1) period of disability as specified on the Summary of Benefits.
- Benefits are not payable during the waiting period specified on the Summary of Benefits.
Benefits will be payable on the basis of a seven-day week.

If benefits due to you are for a fractional part of a week, you will receive one-seventh (1/7) of the weekly benefit for each day of disability.

Your payments will be reduced by the amount of FICA taxes required by law to be withheld.

A period of disability will not be considered to have begun until, at the earliest, the first day that you are actually examined or treated by a Physician for the Injury or Sickness causing the Total Disability.

If a female Employee is Totally Disabled as a result of maternity or a pregnancy or a pregnancy-related condition, the Total Disability will be considered a disability due to Sickness.

AMOUNT AND COMMENCEMENT OF BENEFITS

The amount of your Weekly Disability Benefit depends on whether the Total Disability is due to a Sickness or Injury. It is subject to the schedule contained on the Summary of Benefits under the heading “Weekly Disability Benefit”.

SUCCESSIVE PERIODS OF DISABILITY

When you have two (2) or more periods of disability for the same or a related cause, the Plan may consider them as one (1) period of disability. The second period of disability would be considered a continuation of the first one for benefit purposes. No waiting period is required. Your Weekly Disability Benefit would begin on the first day you are unable to work and would be paid for any remaining weeks in the period of disability. For example, suppose that you were receiving Weekly Disability Benefits. You then recovered and returned to work. Within two (2) weeks, you became Totally Disabled again as a result of that same disability. This would be considered one (1) period of disability.

Now let's assume that you returned to full-time work for a Contributing Employer for two (2) weeks or less (but at least 1 day) and become disabled from a Sickness or Injury different from the one causing your earlier disability. Your second disability is considered separate from the first one for benefit purposes, and a new period of disability (and Waiting Period) applies.
WEEKLY DISABILITY BENEFIT EXCLUSIONS AND LIMITATIONS

No benefits will be payable under these Weekly Disability Benefit Provisions under the following conditions:

- For any disability due to an Injury or Sickness for which the Employee is not under the direct and continuing care of a Physician;

- For any disability that results from any Injury sustained while performing any act or duty pertaining to any occupation or employment for remuneration or profit;

- For any disability which results from any Injury or Sickness for which the Eligible Employee is or may be entitled to receive benefits in whole or in part under the provisions of any workers’ compensation law, occupational diseases law, employer's liability law, no-fault insurance, or similar law;

- For any period of disability during which the Eligible Employee qualifies for unemployment compensation under any federal or state law;

- For any disability that results from any Injury or Sickness sustained as a result of conduct that would exclude payment of benefits for any loss, expense or charge related to such Injury or Sickness under the Plan pursuant to the Plan Conditions, Limitations and Exclusions section of this document, or such Injury or Sickness that otherwise would be excluded from coverage pursuant to such section.

TAXATION OF WEEKLY DISABILITY BENEFITS

In general, Weekly Disability Benefits are subject to Social Security taxes ("FICA"). You pay half of the tax, and the Plan, standing in place of and acting as your employer, pays the other half. According to federal law, the Plan will withhold your share of the FICA tax from each weekly benefit check paid to you during the first six (6) full months of your disability and will send it to the federal government. You must include your Weekly Disability Benefits in your gross income and pay federal income tax on the benefits as income.

You should contact a competent tax advisor or attorney if you have any questions about taxes on your Weekly Disability Benefits.
MAJOR MEDICAL BENEFIT

SUMMARY

This and the next section (Covered Medical Expenses) of the document describe most of the benefits payable when you or your Dependent is injured or sick. When you or a family member incurs charges for benefits payable under this section, an annual deductible will apply. You will also be required to pay the percentage (known as “coinsurance”) of the charges for benefits not covered by the Plan, up to a maximum out-of-pocket amount.

Benefits are payable only to Eligible Individuals for the Reasonable and Customary charges for services described in this document that are Medically Necessary and not otherwise excluded from coverage. Each Covered Expense is deemed incurred on the date the supply or service is provided.

An annual maximum is set for the Essential Health Benefits payable on behalf of any individual under this Plan as well as a lifetime maximum benefit for benefits other than Essential Health Benefits. Those “annual maximum” and “lifetime maximum” are described in this section.

If you have questions about the benefits payable under these sections, please contact the Plan Administrator.

PREFERRED PROVIDER NETWORK

The Plan includes a Preferred Provider Organization (“PPO”) option. A PPO is a network of doctors, Hospitals, and other health care providers who have contracted with this Plan to provide discounted medical services. Eligible Individuals will be issued a PPO ID card and upon request, without charge, a directory listing the member hospitals, labs, and participating doctors. The directory listing can also be accessed online at http://www.bcbs.com. The Plan has contracted to use the Blue Cross/Blue Shield of Minnesota Aware Network for providing services that are determined to be Medically Necessary. If you have any questions about whether a Physician that you would like to see is a member of the network, please contact the Plan Administrator.

You must present your PPO ID card whenever you receive treatment from a PPO provider. The PPO provider will file claims with the Plan directly for Eligible Individuals.

This option provides you and your Eligible Dependents with pre-negotiated discounts for medical treatment provided by in-network providers. You are not, however, required to use a PPO provider. You have freedom of choice each time you seek medical care. At any time, you may choose to use a non-PPO provider, although the price of the services
provided (and, by extension, the dollar amount represented by the applicable coinsurance percentage) will likely be higher than if you use an in-network provider.

**CALENDAR-YEAR DEDUCTIBLES**

**Individual Deductible**

An individual must pay the first $200 of Covered Medical Expenses in a Calendar Year. Once the individual has done so, the individual's deductible has been satisfied and no further deductibles will be required of the individual during the rest of the Calendar Year.

**Family Deductible**

After three (3) or more individuals in your family have paid a total of $600 in Covered Medical Expenses in a Calendar Year, the family deductible has been satisfied. No further deductibles will be required of any member of your family during the rest of the Calendar Year.

**PLAN BENEFITS PAID**

Once the deductible is satisfied, the Plan pays a certain percentage of the charges for Covered Medical Expenses. The remaining percentage is known as “coinsurance”, which you must pay out-of-pocket until you reach the maximum out-of-pocket expense limit specified on the Summary of Benefits. You must also pay any expense not considered a Covered Medical Expense. If you are using an out-of-network provider, you must also pay any charge greater than the Reasonable and Customary Charge. Please note that this coinsurance rule does not apply to vision treatments or prescription drug coverage. There is a separate and distinct maximum out-of-pocket expense limit specified on the Summary of Benefits, which you must satisfy for prescription drug coverage. Co-insurance paid as part of the prescription drug benefits coverage will not count towards satisfaction of the maximum out-of-pocket expense limit for major medical benefits, and co-insurance paid as part of the major medical benefit coverage will not count towards satisfaction of the maximum out-of-pocket expense limit for prescription drug benefits coverage.

The amount of your coinsurance is twenty (20%) percent (except as indicated).

To see how the Plan’s coinsurance provisions work, see the examples, below.

**DEDUCTIBLE RULES**

- All deductibles are based on an accumulation period of a Calendar Year (January 1 through December 31 of each year).
- Only your payments for Covered Medical Expenses can be used to satisfy a deductible.
If an eligible family member is suffering from a condition for which Covered Medical Expenses are incurred in two (2) or more years, the deductible must be satisfied each year.

Each eligible family member must satisfy the individual deductible each year, except that once the family deductible is satisfied during a Calendar Year, no further individual deductibles must be satisfied by any other family members during that Calendar Year.

**LIFETIME MAXIMUM BENEFIT**

The Plan will pay Major Medical Benefits other than Essential Health Benefits on behalf of an Eligible Individual up to the lifetime major medical maximum benefit specified on the Summary of Benefits. Once an Eligible Individual has reached that limit, the Plan will not pay any more Major Medical Benefits other than Essential Health Benefits on behalf of that Eligible Individual.

For example, by June 2007, the Plan has paid Major Medical Benefits other than Essential Health Benefits on Shannon’s behalf equal to the lifetime major medical maximum benefit specified on the Summary of Benefits. She will not be entitled to any more Major Medical Benefits under the Plan for the rest of her life other than Essential Health Benefits.

**MAXIMUM OUT-OF-POCKET EXPENSE**

There is a limit on the amount of coinsurance you must pay in a Calendar Year. Please see the Summary of Benefits for the dollar amounts. Once you have reached the limit, the Plan pays one hundred (100%) percent of Covered Expenses for the rest of the year.

**EXAMPLE:** If you have incurred $7,000 worth of Covered Medical Expenses, the amount that you will be responsible for is illustrated below:

<table>
<thead>
<tr>
<th>In-Network Charges</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>You have Covered Medical Expenses of</td>
<td>$7,000</td>
</tr>
<tr>
<td>You pay the individual deductible</td>
<td>- 200</td>
</tr>
<tr>
<td></td>
<td>$6,800</td>
</tr>
<tr>
<td>You pay twenty (20%) percent of the remaining expenses</td>
<td>- 1,360</td>
</tr>
<tr>
<td>(the coinsurance) because you have not yet reached the</td>
<td></td>
</tr>
<tr>
<td>out-of-pocket maximum of $3,000 in a Calendar Year.</td>
<td></td>
</tr>
<tr>
<td>The Plan pays</td>
<td>$5,440</td>
</tr>
<tr>
<td>You would still have to pay $1,640 in coinsurance on</td>
<td></td>
</tr>
<tr>
<td>future charges during the Calendar Year before reaching</td>
<td></td>
</tr>
<tr>
<td>the out-of-pocket maximum of $3,000.</td>
<td></td>
</tr>
</tbody>
</table>
If the service that you received contains an annual or lifetime maximum benefit, only the amount of your out-of-pocket expense which is sufficient to permit the Plan to reach the annual or lifetime maximum is counted toward your maximum out-of-pocket expense.

In other words, amounts you pay for a service subject to an annual or lifetime maximum do not always fully count towards reaching your out-of-pocket expense limit. To determine what portion does count, first determine how large the bill would need to be in order to reach the annual or lifetime maximum. Then subtract the percentage the Plan would pay for the service. The result is the ceiling on the amount of your payment that counts toward reaching the limit.

**EXAMPLE**

Heidi incurs a $10,000 charge for medical foods. The Plan limit for medical foods is $5,000, so the Plan pays $5,000, and Heidi pays $5,000. Not all of Heidi’s payments count towards her out-of-pocket expense limit. To determine what portion does count, divide the $5,000 annual maximum (or the remaining portion of the annual maximum) by eighty (80%) percent, to see how large the bill would have to be for the Plan’s payment to reach the annual maximum: $6,250 (that is, a $6,250 charge covered at eighty (80%) percent would equal $5,000, the annual maximum). Then subtract the $5,000 the Plan would pay. The result, $1,250, is the ceiling on the amount of Heidi’s out-of-pocket expense that counts toward her out-of-pocket maximum limit.

Again, only the total coinsurance paid of the amount of charges that would generate Plan payments up to the applicable annual or lifetime benefit maximum counts towards the out-of-pocket maximum limit.

If you have any questions about determining the amount of your out-of-pocket expense that will count towards your maximum out-of-pocket amount, please contact the Plan Administrator.

| Deductibles, Out-of-Pocket expenses and Maximums are calculated separately for each Eligible Individual. |
COVERED MEDICAL EXPENSES

The Plan’s Major Medical Benefit will pay the Reasonable and Customary Charges for the treatment of a covered Sickness or Injury of you or your Eligible Dependent’s, subject to the Plan’s Conditions, Limitations, and Exclusions.

Covered Medical Expenses include the Reasonable and Customary Charges for the following services, supplies and types of treatment:

HOSPITAL EXPENSE BENEFIT

Room and Board

Hospital daily Room and Board Charges, at the Hospital’s semi-private room rate, general duty nursing and any other charges by whatever name called which are regularly made by the Hospital as a condition of occupancy of the class of accommodations occupied, but NOT including charges for private duty nurses or charges for intensive nursing care. If a private room is used, only the Hospital’s most common charge for a semi-private room will be considered a Covered Medical Expense.

Maternity Expenses

When pregnancy causes an Eligible Individual to incur expense while this coverage is in effect as to such individual, the Plan will consider the Reasonable and Customary expense actually incurred in the same manner as any other Sickness or accidental bodily Injury. As used in this section, “pregnancy” includes spontaneous abortion, miscarriage, normal childbirth, cesarean section, extra-uterine pregnancy, or any complications arising from such occurrences and conditions.

This 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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a caesarian section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, this Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).
Emergency Room Expenses

The Plan requires each Eligible Individual to pay $100 copayment per each emergency room visit. Emergency Room visits are subject to any applicable deductible and coinsurance. The copayment does not apply to the Calendar Year deductible or the out-of-pocket maximum benefit limitation. The copayment continues to apply even if the Eligible Individual reaches the out-of-pocket maximum. The copayment will be waived if the Eligible Individual is admitted as an inpatient to the hospital.

Other Hospital Expenses

Other Hospital services and supplies, which are the Medically Necessary services and supplies provided by a Hospital which are required for the treatment of an Eligible Individual, excluding Room and Board Charges, and private duty nursing care, not to exceed the Reasonable and Customary expense for the applicable procedure.

TRANSPORTATION SERVICES

Transportation services as specified below, provided that the Eligible Individual is too ill or injured to travel by other modes of transportation:

- Required emergency local transportation by a professional ambulance service, limited to the first trip to the nearest Hospital qualified to provide treatment for the applicable Sickness or Injury; and

- If the attending Physician certifies that an Eligible Individual's Sickness or Injury requires specialized or unique treatment that is not available in a local Hospital, expenses incurred for transportation of the individual to obtain the treatment will be considered Covered Medical Expenses, subject to the following provisions:
  1. The transportation must be by regularly scheduled commercial airline or railroad or by professional air ambulance;
  2. The transportation may only be from the town where the Injury or Sickness occurred to the nearest Hospital qualified to provide the special treatment, which may or may not be the Hospital where the individual wants to be treated;
  3. Only the first trip to and from the Hospital for any one (1) Sickness and for all Injuries resulting from any one (1) accident is covered; and
  4. The transportation is limited to the United States or Canada.
PROPHYLACTIC MASTECTOMY AND OOPHORECTOMY BENEFIT

The Plan will cover surgical procedures relating to prophylactic mastectomies and post-mastectomy reconstructive surgery when one (1) or more of the following risk factors are present in the Eligible Individual.

- A strong family history of breast cancer. A “strong family history of breast cancer” will mean that: (a) two (2) or more first degree relatives of the Eligible Individual have been diagnosed with breast cancer; or (b) three (3) or more first or second degree relatives of the Eligible Individual have been diagnosed with breast cancer. If the Eligible Individual is an only child, coverage will be determined on a case by case basis;

- Cancer in one (1) breast and a first degree relative with a history of breast cancer;

- A first degree relative with bilateral pre-menopausal breast cancer;

- A biopsy diagnosis of lobular carcinoma or atypical hyperplasia and either (a) a first degree relative with breast cancer, or (b) breast tissue density, scarring or calcification which precludes follow-up mammographies and physical examinations;

- A family history of hereditary cancer, defined as Cowden’s Disease, SBLA Syndrome or Ovarian/Breast Cancer Syndrome, and documented by family pedigree;

- A positive test for BRCA1 or BRCA2 mutant genes; or

- A significant risk of breast cancer due to prior medical treatment, as demonstrated by competent medical evidence and opinion of the Eligible Individual’s medical doctor.

The Plan will cover surgical procedures relating to prophylactic oophorectomies when one (1) or more of the following risk factors are present in the Eligible Individual.

- Over age forty (40) with a diagnosis of hereditary ovarian cancer syndrome based on a family pedigree constructed by a genetic counselor or physician competent in determining the presence of autosomal dominant inheritance pattern;

- A personal history of breast cancer and at least one (1) first degree relative with a history of ovarian cancer;

- Two (2) or more first degree relatives with a history of ovarian cancer;
Eligible Individuals are required to submit proposed procedures to the Plan in advance for authorization. The Trustees of the Plan reserve the right to require a second medical opinion by a medical doctor of the Plan’s choosing supporting the medical necessity for the proposed procedure. The expenses associated with any second opinion will be paid by the Plan. The Eligible Individual must submit to a reasonable medical examination by the Plan’s medical doctor if such doctor requires one to support the second medical opinion. The Trustees of the Plan may also require that procedures under this section be managed by a case manager of the Plan’s choosing.

For purposes of this section, “first degree relatives” are defined as an Eligible Individual’s natural mother, sister, or daughter. “Second degree relatives” are defined as an Eligible Individual’s natural first cousins, aunt, niece or grandmother.

**CONVALESCENT FACILITY BENEFIT**

These are the charges made by a Convalescent Facility, on its own behalf, for the following services and supplies furnished by the facility. The charges will be incurred by the Eligible Individual solely during confinement during a Convalescent Period, while convalescing from the Sickness or Injury for which the individual is confined:

- Room and Board. However, if private accommodations are used, any excess of daily Room and Board Charges over the Convalescent Facility’s semi-private rate will not be considered a Covered Expense.

- Use of special treatment rooms; x-rays and laboratory examinations; physical, occupational, or speech therapy; oxygen and other gas therapy; and other medical services, except private duty or special nursing services and Physicians’ services customarily provided by Convalescent Facilities.

- Drugs, solutions, dressings, and casts, but not other supplies.

A "Convalescent Period” is a period of consecutive days of confinement in a Convalescent Facility. It will begin on the first day on which the individual becomes confined in a Convalescent Facility for the purpose of receiving skilled nursing and physical restoration services for convalescence from an Injury or Sickness for treatment of which he or she has previously been confined in a Hospital for at least three (3) consecutive days while covered by this Plan, provided the Convalescent Facility confinement commences within fourteen (14) days following discharge from the Hospital confinement.
The Convalescent Period will end ninety (90) days after the last day during which the family member was confined in a Hospital, a Convalescent Facility, or any other institution providing nursing care.

Limitations and Exclusions

- Convalescent Facility charges are included as Covered Medical Expenses for a maximum of one hundred twenty (120) days in any Calendar Year in connection with all Convalescent Facility confinements of the covered family member during any one (1) Convalescent Period.

- Convalescent Facility expenses are not included as Covered Medical Expenses if they are incurred in connection with the treatment of chemical abuse, chronic brain syndrome, alcoholism, mental retardation, senility, or any mental disorder.

- The Plan's definition of “Room and Board” and the provisions of the Plan relating to payment of claims will be applicable to a Convalescent Facility to the same extent as they are applicable to a Hospital.

HOME HEALTH CARE BENEFIT

These are the charges made by a Home Health Care Agency for the following services or supplies furnished to a covered family member in such family member's home, in accordance with a Home Health Care Plan.

- Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) if the services of a registered graduate nurse (R.N.) are not available.

- Part-time or intermittent home health aide services which consist primarily of caring for the patient.

- Physical therapy, occupational therapy, and speech therapy.

- Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Home Health Care Agency, but only to the extent that the charges would have been covered under this Plan if the Eligible Individual had been confined in a Hospital or Convalescent Facility.

Limitations and Exclusions

- Home Health Care visits are limited to a maximum of one hundred twenty (120) visits in a Calendar Year. Each visit to a family member's home by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) to provide nursing care, by a therapist to provide physical, occupational, or speech therapy, and each visit of up to four (4) hours by a home health aide, will be considered as one (1) Home Health Care visit.
Home Health Care Expenses will not be included as Covered Medical Expenses if they are:

1. For services or supplies not specified in the Home Health Care Plan;

2. For services of an individual who ordinarily resides in the Employee's home or is a member of the family of either the Employee or the Employee's spouse;

3. For the services of any social worker;

4. For transportation services.

HOSPICE CARE BENEFIT

These are the charges made for the following services and supplies furnished to a covered family member for Hospice Care when given as a part of a Hospice Care Program.

Facility Expenses

These are the charges made, in its own behalf, by a Hospice Facility, Hospital, or Convalescent Facility which are for:

1. Room and Board and other services and supplies furnished to a covered family member for pain control and other acute and chronic symptom management. If a private room is used, any part of the daily Room and Board limit over the semi-private rate will not be considered a Covered Expense. Also not included is the charge for any day of Hospice Care in excess of thirty (30) days for all confinements for Hospice Care, unless additional days are approved by the Plan.

2. Services and supplies furnished to a family member while not confined as a full-time inpatient.

Other Expenses

These are charges made by:

1. A Hospice Care Agency for:

   a. Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.) for up to eight (8) hours in any one (1) day;
b. Medical social services, under the direction of a Physician, which include:

i. Assessment of the family member's social, emotional, and medical needs and the home and family situation;

ii. Identification of the community resources which are available to the family member;

iii. Assisting the family member to obtain those resources needed to meet the family member's assessed needs;

c. Psychological and dietary counseling;

d. Consultation or case management services by a Physician;

e. Physical and occupational therapy;

f. Part-time or intermittent home health aide services, which consist mainly of caring for the family member, for up to eight (8) hours in any one (1) day; and

g. Medical supplies, drugs, and medicines prescribed by a Physician.

2. The following providers, but only if the provider is not an employee of a Hospice Care Agency and such agency retains responsibility for the care of the family member:

a. A Physician for consultant or case management services;

b. A physical or occupational therapist;

c. A Home Health Care Agency for:

i. Physical or occupational therapy;

ii. Part-time or intermittent home health aide services, which consist mainly of caring for the family member, for up to eight (8) hours in any one (1) day;

iii. Medical supplies, drugs, and medicines prescribed by a Physician; and

iv. Psychological and dietary counseling.
Limitations and Exclusions:
In no event will Hospice Care Expenses include charges made for:

- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling which includes estate planning or the drafting of a will;
- Homemaker or caretaker services, which are services not solely related to care of the covered family member, including:
  1. Sitter or companion services for either the family member who is ill or other members of the family;
  2. Transportation;
  3. Housecleaning;
  4. Maintenance of the house; and
- Respite care, which is care furnished during a period of time when the covered family member's family or usual caretaker cannot, or will not, attend to the family member's needs.

REPLACEMENT OF ORGANS AND TISSUE BENEFIT

The Plan covers expenses for services, supplies, drugs, and related aftercare for certain human organ and tissue transplant and bone marrow transplant and stem cell support procedures which are Medically Necessary, which are not Experimental or Investigative, which are payable under all other provisions of this Plan document, and which meet the following Special Requirements for Transplant Procedures.

Procedures Not Subject to Special Requirements
Charges incurred for kidney (except kidney transplants from a live donor), cornea, and skin transplants are covered on the same basis as any other Covered Expense and are not subject to the Special Requirements for Transplant Procedures listed below.
Procedures Subject to Special Requirements

The following transplant procedures have been determined by the Plan's Board of Trustees not to be Experimental or Investigative and are approved for coverage subject to the Special Requirements for Transplant Procedures listed below:

1. Kidney (received from a live donor)
2. Heart
3. Heart-lung
4. Liver
5. Lung (single or double)
6. Pancreas transplant for:
   a. A diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session, or
   b. A medially uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.
7. Bone marrow transplant and stem cell support procedures as follows:
   b. Autologous bone marrow and autologous peripheral stem cell support for: acute lymphocytic or non-lymphocytic leukemia, acute and chronic myelogenous leukemia, chronic granulocytic leukemia, breast cancer, advanced Hodgkin's lymphoma, advanced Non-Hodgkin's lymphoma, advanced neuroblastoma, multiple myeloma (newly diagnosed or chemotherapy responsive), Ewing's sarcoma, autoimmune thrombocytopenia purpura, autoimmune hemolytic anemia/pure red cell aplasia, rheumatoid and juvenile rheumatoid
arthritis, systemic lupus erythmatosus, and testicular Mediastinal, and Retroperitoneal germ cell tumors.

c. Not covered are services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs and aftercare for or related to bone marrow transplant, stem cell support or peripheral stem cell support procedures for a condition not specifically listed above as covered. Conditions specifically excluded from coverage in connection with the preceding sentence include, but are not limited to: malignant melanoma and other skin cancer, lung cancer, prostate cancer, brain tumors, uterine and cervical cancer, epithelial cell tumors of the ovary, colon cancer and other gastrointestinal tract cancers including the pancreas.

The Plan’s Board of Trustees reserves the right to change (but is not required to change) the above list of transplant procedures which are approved for coverage.

**Special Requirements for Transplant Procedures**

1. Plan Authorization for a transplant procedure must be obtained from the Plan Administrator before the procedure is scheduled.

2. Transplant procedures are subject to case management by the Plan or a case manager designated by the Plan. At the time that a request for authorization is made, the Plan Administrator will identify the Plan’s case manager assigned to the transplant procedure.

3. Coverage is limited to two (2) transplant procedures for the same condition per individual per lifetime.

4. If the transplant recipient is covered by this Plan, but the donor is not, medical expenses of the donor will be eligible for payment by the Plan up to a maximum benefit of $20,000, but only to the extent they are not covered by any other plan of benefits. Weekly Disability Benefits will not be payable to an organ or tissue donor unless the donor is an Employee otherwise eligible for the benefits.

5. If the transplant donor is covered under this Plan, but the recipient is not, benefits will be considered for payment under the Plan only to the extent they are not payable under any other plan of benefits. Benefits for expenses incurred by the recipient will not be payable.

6. A request for authorization of a transplant procedure must be supported by the written opinion of a Physician who is board certified as a specialist.
in the field of surgery applicable to the transplant procedure to the effect that:

a. Identifying the proposed recipient's medical condition for which the transplant procedure is requested, and

b. Certifying that the proposed transplant procedure is Medically Necessary to the treatment of the proposed recipient's condition and is not Experimental or Investigative as applied to such condition.

c. Certifying that no alternative procedure, service, or course of treatment would be effective in the treatment of the proposed recipient's condition.

Additionally, a written second opinion of a Legally Qualified Physician will be required for all proposed transplant procedures.

7. Not covered (i.e. excluded) are expenses related to:

a. Services or supplies not reimbursed under the provisions of this Plan.

b. Services unrelated to the covered transplant procedure or unrelated to the diagnosis or treatment of a Sickness resulting directly from such transplant.

c. Physicians', Hospitals' and other covered health care providers' services or supplies for which no charge is made or, further, for which no charge would routinely be made in the absence of insurance.

d. Transplantation or implantation of a non-human organ or tissue.

e. Use of a left ventricular-assist device or any similar equipment as part of clinical trials for research or for a period in excess of thirty (30) days, consecutive or not, per covered transplant procedure.

f. Implant of an artificial or mechanical heart or part of such implant.

g. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from the Hospital after transplant surgery.

h. Drugs or medicines which are Experimental or Investigative, are used in clinical trials or research, which are not widely accepted and used by the medical community, or which have not been
approved for general sale and distribution by the U.S. Food & Drug Administration.

i. Air Ambulance transportation, except with respect to the transportation of the organ to the location of the surgery when such location is within a five hundred (500) mile radius. In the event of an emergency the five hundred (500) mile radius restriction will be waived; however, in no event will such waiver apply to organs obtained outside of the United States or Canada.

j. Living donor transplants of the liver, lung or any other organ, such as selective islet cell transplants of the pancreas.

k. Retransplant of organ or bone marrow during the three hundred sixty-five (365) day period following the transplant procedure.

DEVELOPMENTAL DELAY THERAPY SERVICES

The Plan will cover physical, occupational and speech therapy services provided for covered Dependent children for the treatment of developmental delay. The maximum benefit is a total of one hundred (100) visits per lifetime for physical, occupational and speech therapy services (combined).

In order to qualify for the Developmental Delay Therapy Services benefit under the Plan, the services provided to the Dependent child must meet the requirements for Developmental Delay Therapy Services as provided in the Definitions section of this document. Additionally, the Eligible Employee must provide evidence to the Plan that similar benefits are either: (1) not available through the child’s school district, or (2) that the services provided through the school district are not sufficient to reasonably be expected to produce significant improvement in the child’s condition in a reasonable and predictable time period.

The Developmental Delay Therapy Services benefit does not include services which are:

1. Rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness, which are covered elsewhere in the Plan);

2. For the purpose of maintaining physical function (maintenance therapy); or

3. Educational in nature.
OTHER MAJOR MEDICAL BENEFITS

The following charges are considered "Other Major Medical Expenses", provided that they have not been considered as any other Covered Medical Expense. They will include the Reasonable and Customary Charge for the following:

1. Blood and blood plasma and its administration;
2. Anesthesia;
3. X-ray and Laboratory examinations;
4. Physiotherapy;
5. Casts, splints, trusses, braces and crutches;
6. Oxygen and the rental of equipment for its administration;
7. Rental or purchase of durable medical equipment, such as a wheelchair, hospital-type bed, iron lung, or other similar item. Decisions related to payment of benefits under this provision, including, but not limited to, determinations of whether equipment should be rented or purchased, repaired or replaced, and the type of equipment most suited to a particular application will be made by the Trustees.

The Plan will provide benefits for the reasonable repair of durable medical equipment occasioned by ordinary wear and tear.

The Plan will cover the replacement of durable medical equipment only if the original equipment has reached the end of its useful life and is worn out beyond repair, the equipment cannot be repaired, the cost of replacement is lower than the cost of repair, substitute equipment of a different type is medically necessary due to the Eligible Individual’s changed condition, or the Eligible Individual is a child and replacement of the equipment is necessitated by growth;

8. Charges for skilled nursing services performed by registered graduated nurses (R.N.) and licensed practical nurses (L.P.N.) if such skilled nursing services are approved in advance by the Plan as Medically Necessary;
9. Surgery to reconstruct a breast following a mastectomy procedure on the affected breast and (1) any surgical procedure on the non-affected breast which is intended to provide a symmetrical appearance; (2) prostheses, implants, and up to four (4) brassieres per year following the mastectomy for simulating natural body contours; and (3) the treatment of any physical complications associated with the mastectomy procedure;
10. Wigs for hair loss related to chemotherapy and radiation treatment;

11. Surgical supplies, including appliances to replace physical organs or parts of organs which are lost while the Eligible Individual is Covered Under the Plan. These include such items as artificial limbs and eyes. Only the initial charge for any such appliance will be considered a Covered Medical Expense except when bodily changes impact the use of the appliance. Also included as a Covered Medical Expense will be the first charge incurred for surgical supplies required to aid any impaired physical organ or part of an organ in its natural body function;

12. Dental treatment, limited to treatment of accidental Injury to sound natural teeth, including repair and the initial replacement of the teeth and prosthetic appliances and any necessary dental x-rays, provided that treatment is begun within six months following the date of the accident that caused the Injury. Treatment is also subject to the “Exclusions from Coverage” listed in the “Dental Benefits” section of this document;

13. Charges for professional services rendered by a Physician for medical care and treatment, including services provided by a Physician when the service is provided to an Eligible Individual at a Hospital as an outpatient or at a medical clinic or at the Physician's office;

14. Charges for genetic counseling and genetic testing;

15. Charges for orthoptics, vision therapy, or aniseikonia not exceeding thirty (30) visits per lifetime;

16. Charges for the following preventative care:

Since the following services are for preventative care, they are not subject to the requirement that they be incurred for the treatment of a non-occupational accidental bodily Injury or Sickness. However, the Plan will not pay more than the Reasonable and Customary Charges for these services.

a. Immunizations.

b. Routine Physical Examinations.

c. The following procedures relating to colorectal cancer screening:

- Fecal Occult Blood Test
- Flexible Sigmoidoscopy
- Flexible Colonoscopy
- Colon Barium Enema
17. Medical Foods for individuals with Inherited Metabolic Disorders, but only if the Medical Foods are prescribed by a Physician to treat a diagnosis of Inherited Metabolic Disorder; the patient requires specially processed or treated Medical Foods that must be consumed throughout life and may suffer serious mental or physical impairment without them; and the patient is under the regular supervision of a Physician to monitor the Inherited Metabolic Disorder; and only once the Plan Administrator has received documentation substantiating the presence of an Inherited Metabolic Disorder and that the products purchased are Medical Foods; subject to an Annual Maximum benefit of $5,000;

18. Gastric bypass surgery (including services related to surgical complications and follow-up surgery to remove excess skin), subject to a Lifetime Maximum of $25,000, but only for an individual who has:

a. A BMI of at least 40 (or, for an individual with coronary heart disease, Type II diabetes, clinically significant obstructive sleep apnea, systolic blood pressure exceeding 140, or diastolic blood pressure exceeding 90, a BMI of at least 35); and

b. Participation in a Physician-supervised nutrition and exercise program of at least six (6) months duration, occurring within the two (2) years prior to the surgery. The nutrition and exercise program must minimally include dietician consultation, a low calorie diet, increased physical activity and a behavioral modification program. Participation in the program must be documented in the medical record by an attending Physician who does not perform weight loss surgery. The documentation necessary to receive this benefit includes the medical records of the Physician’s ongoing assessment of the individual’s progress throughout the course of the nutrition and exercise program. A Physician’s summary letter will be insufficient to meet this requirement. However, if the individual participates in a Physician-administered nutrition program such as MediFast or Optifast, program records documenting the individual’s participation and progress may substitute for Physician medical records;

c. The Plan will pay the cost of a weight-loss program, including pharmaceutical treatments, subject to the Plan’s coinsurance provisions and up to an annual maximum benefit of $750 per consecutive two-year period and available only once every ten (10) years. Eligibility for the weight-loss program benefit will be subject to the following:

i. A BMI of 25 or greater;
ii. Participation in a Physician-supervised nutrition and exercise program that includes all of the following components:

1) Dietician consultation;
2) Low calorie diet;
3) Increased physical activity, and;
4) Behavior modification program.

d. If used in preparation for the gastric bypass benefit, the above noted weight loss program must be documented as part of the individual’s medical record.

19. Jobs stockings, subject to an Annual Maximum benefit of four (4) per Calendar Year.
MENTAL HEALTH EXPENSE BENEFIT

SUMMARY

The Plan’s Mental Health Expense Benefit contains provisions for the treatment of both mental health issues and chemical dependency problems. These benefits are coordinated through T.E.A.M., Inc., a local organization that can assist you with these issues.

T.E.A.M., Inc. is a valuable resource. You may contact them at (651) 642-0182, or the Plan Administrator if you or one of your Dependents needs assistance with family, marital, alcohol, drug, or other personal problems.

FAMILY ASSISTANCE PROGRAM PROVIDED THROUGH T.E.A.M., INC.

From time to time, we all deal with personal problems, both large and small. Sometimes we need help to resolve our problems. Your Family Assistance Program, provided through T.E.A.M., Inc., is a confidential assessment, counseling, and referral service for you and your Eligible Dependent to help resolve personal problems which may be affecting your life at work and at home. This program is also available to Eligible Retirees.

Skilled counselors are available twenty-four (24) hours a day, every day of the year, to talk with you in confidence about your problems. Your T.E.A.M., Inc. counselor can help you with:

- Family and marriage problems
- Alcohol or controlled substance dependency
- Financial concerns
- Emotional problems
- Legal referrals
- Medical concerns
- Work-related problems

For example, your counselor can help you find a nursing home for your father, recommend a new physician, counsel a chemically dependent individual in your family, locate a marriage counselor for long-term counseling, or find a financial counselor to help you plan your budget. Talking to a professional about your problems can often help you gain a fresh perspective.

T.E.A.M., Inc., also provides services in coordinating assessments of Eligible Individuals who are diagnosed with conditions which are otherwise excluded from coverage under Exclusion No. 10 of the “Mental Health Expense Benefit Exclusions”.

63
The Carpenters and Joiners Welfare Fund  Mental Health Expense Benefit

The conditions under which such assessments are a Covered Expense are described under the heading “Additional Mental Health Assessment Benefit” below.

**How to Use Your Family Assistance Program**

If you need help with a problem, just dial the confidential hotline at (651) 642-0182 or 1-800-634-7710. Some problems can be resolved with a counselor in just a few minutes over the phone. Or, you may choose to schedule a meeting with a counselor at any of T.E.A.M., Inc.'s convenient locations. You may find out more about this program by visiting their Website at www.team-mn.com. You may also call the Plan Administrator.

At the first meeting, which lasts about one (1) hour, your counselor will discuss your problems with you and determine the type of assistance you need. More meetings with your same counselor can be made, or, if you and the counselor decide that long-term counseling or treatment is needed, your counselor will refer you to an appropriate agency. Your counselor will follow up to make sure that you were satisfied with the service received and that your problem is being resolved.

The assessment, short-term counseling, and referral services are paid for by the Plan. If you are referred for long-term counseling or treatment, you are responsible for the cost of these services. The Plan may cover some of the long-term counseling and treatment costs associated with the care of chemical dependency, alcoholism, and mental and nervous disorders. Your counselor will consider your particular employee benefits situation when suggesting a referral.

**TREATMENT OF MENTAL OR NERVOUS DISORDERS**

The Plan will pay for full-time in-patient confinement in a Hospital or in an approved treatment facility and for outpatient treatment (whether for individual, group, or family therapy), subject to the Maximum Benefits and limitations applicable to Covered Medical Expenses and the provisions and limitations of this Section “Mental Health Expense Benefit,” so long as all of the following requirements are satisfied:

1. The program is properly licensed.
2. The treatment is in a:
   a. Licensed or accredited Hospital: or  
   b. Community health center or mental health clinic approved or licensed by the Commissioner of Public Welfare or other authorized state agency.
3. The treatment or service is pursuant to the diagnosis and/or recommendation of an Approved Mental Health Provider.
4. The treatment is provided by an Approved Mental Health Provider.
For this purpose, an “Approved Mental Health Provider” is one (1) of the following:

- Certified Nurse Specialist (C.N.S.)
- Child Psychiatrist holding an M.D.
- Child Psychologist holding a Ph.D., M.A., or M.S.W
- Clinical Psychiatrist holding an M.D.
- Clinical Psychologist holding a Ph.D., M.A., or M.S.W.
- Licensed Independent Clinical Social Worker (L.I.C.S.W.)
- Licensed Marriage and Family Therapist (L.M.F.T.)
- Licensed Professional Counselor (L.P.C)
- Licensed Therapist holding an M.A. or M.S.W. whose work is supervised by a Psychiatrist or Psychologist who would be considered an Approved Mental Health Provider
- Medical Doctor (M.D.)
- Physician’s Assistant (P.A.)

Additional Mental Health Assessment Benefit

If an Eligible Individual is diagnosed with a condition which is excluded from coverage because it is listed in item No. 10 of the “Mental Health Expense Benefit Exclusions,” the Plan will pay for additional diagnostic services to assess the condition if:

1. The Eligible Individual contacts T.E.A.M., Inc., and
2. The assessment is performed by a provider approved by T.E.A.M., Inc., and in accordance with a T.E.A.M., Inc., approved assessment plan.

The treatment of conditions listed in Exclusion No. 10 is not a Covered Expense, but if the assessment results in a further diagnosis of a condition which is not excluded from coverage, then treatment of conditions listed in Exclusion No. 10 is a Covered Expense.

TREATMENT OF CHEMICAL DEPENDENCY

The Plan will provide the following coverage for Chemical Dependency Treatment, which includes treatment for either alcohol or drug related problems.
The Carpenters and Joiners Welfare Fund  Mental Health Expense Benefit

Maximum Benefit
The Plan will pay eighty (80%) percent of Covered Expenses incurred for in- and out-patient treatment of alcoholism, chemical dependency, or drug addiction.

Detoxification Treatment
The Plan will pay for Covered Expenses incurred for detoxification in a treatment facility for alcoholism/drug addiction subject to the provisions and limitations applicable to Covered Medical Expenses and the provisions and limitations of this Section "Mental Health Expense.

In-Patient Rehabilitative Treatment
Payment of Benefits
After satisfaction of the applicable Calendar Year deductible, the Plan will pay for Covered Expenses incurred for confinement for rehabilitative treatment, subject to the provisions and limitations of this Section "Mental Health Expense. The following rules also apply:

1. The Eligible Individual must be Covered Under the Plan at the time the course of treatment is received.
2. The program must be properly licensed.
3. The treatment must be in a licensed or accredited Hospital; or in a community health center or mental health clinic approved or licensed by the Commissioner of Public Welfare or other authorized state agency.
4. Covered Expenses for out-patient treatments include charges for treatment by a Doctor of Medicine, Clinical or Child Psychiatrist holding an M.D., Clinical or Child Psychologist holding a Ph.D. or M.A., or a Licensed Therapist holding an M.A. or M.S.W. degree whose work is supervised by either a Psychologist or a Psychiatrist.

Out-Patient Rehabilitative Treatment
The Plan will pay benefits for Covered Expenses incurred for out-patient rehabilitative treatment at which the patient is present, whether incurred for individual therapy, group therapy, or family therapy, subject to the provisions and limitations applicable to Covered Medical Expenses and the provisions and limitations of this Section "Mental Health Expense Benefit." The following rules also apply:

1. The Eligible Individual must be Covered Under The Plan at the time the course of treatment is received.
2. The program must be properly licensed.
3. The treatment is in a licensed or accredited Hospital; or in a community health center or mental health clinic approved or licensed by the Commissioner of Public Welfare or other authorized state agency.

4. Covered Expenses for out-patient treatments include charges for treatment by a Doctor of Medicine, Clinical or Child Psychiatrist holding an M.D., Clinical or Child Psychologist holding a Ph.D. or M.A.; or a Licensed Therapist holding an M.A. or M.S.W. degree whose work is supervised by either a Psychologist or a Psychiatrist.

MENTAL HEALTH EXPENSE BENEFIT EXCLUSIONS

Covered Expenses will not include and no payment will be made by the Plan with respect to any treatment under this Mental Health Expense Benefit for any of the following:

1. Any portion of a charge that is in excess of the Reasonable and Customary Charge for the treatment.

2. Charges incurred for diagnosis and treatment of behavioral problems.

3. Charges incurred for diagnosis and treatment of learning disabilities.

4. Charges incurred for marital counseling, except as determined medically appropriate.

5. Charges incurred for any type of expense which is excluded under the Plan's "Major Medical Benefit" unless specifically stated as covered under the Plan's “Other Major Medical Benefits”.

6. Charges incurred for any in-patient confinement in a Hospital which does not meet this Plan's definition of a Hospital or, with respect to treatment of alcoholism or drug addiction, in a treatment facility which does not meet this Plan's definition of a treatment facility for alcoholism/drug addiction.

7. Charges incurred for any type of expense which is excluded under the "Plan Conditions, Limitations and Exclusions".

8. Charges incurred once an Eligible Individual has received any maximum benefit stated on the Summary of Benefits during any stated period of time.

9. Charges incurred for any program of aversion treatment for alcoholism or drug addiction except as determined to be medically appropriate.
10. Charges incurred for diagnosis and treatment primarily relating to the following diagnosis (taken from ICD-9-CM (International Classification of Diseases, 9th Review Clinical Modification, Volumes 1, 2, & 3), except that additional diagnostic assessment services performed after an Eligible Individual receives a listed diagnosis are Covered Expenses if the assessment is obtained as provided in “Additional Mental Health Assessment Benefit”, above:

Conduct Disorders

312.00 undersocialized, aggressive
312.10 undersocialized, non-aggressive
312.23 socialized, aggressive
312.21 socialized, non-aggressive
312.90 atypical

Specific Development Disorders

315.00 developmental reading disorder
315.10 developmental arithmetic disorder
315.31 developmental language disorder
315.39 developmental articulation disorder
315.50 mixed specific developmental disorder
315.90 atypical specific developmental disorder

Disorders of Impulse Control not Elsewhere Classified

312.31 pathological gambling
312.32 kleptomania
312.33 pyromania
312.34 intermittent explosive disorder
312.35 isolated explosive disorder
312.39 atypical impulse disorder

V Codes for Conditions not Attributable to a Mental Disorder that are a Focus Not Covered of Attention or Treatment

V65.20 Malingering
V62.89 Borderline intellectual functioning (V62.88)
V71.01 Adult antisocial behavior
V71.02 Childhood or adolescent antisocial behavior
V62.30 Academic problem
V62.20 Occupational problem
V62.82 Uncomplicated bereavement
V15.81 Noncompliance with medical treatment
V62.89 Phase of life problem or other life circumstance problem
V61.10  Marital problem  
V61.20  Parent-child problem  
V61.80  Other specified family circumstances  
V62.81  Other interpersonal problem

11. Charges incurred for methadone maintenance except as determined medically appropriate.

MENTAL HEALTH EXPENSE BENEFIT LIMITATIONS

1. Benefits for care and treatment of the Eligible Individual for treatment of alcoholism and/or drug addiction are subject to the provisions and limitations applicable to Covered Medical Expenses, as stated in the Summary of Benefits.

2. Charges dealt with under the general Major Medical Benefit or Treatment of Chemical Dependency provisions of the Plan may not be considered for payment under the Treatment of Mental and Nervous Disorders provisions of the Plan.

3. No benefits will be payable for the Treatment of Mental or Nervous Disorders unless the benefits are consistent with the report of the attending Approved Mental Health Provider and until that report has been reviewed by the Plan Administrator.
VISION EXPENSE BENEFIT

SUMMARY
The Plan provides Vision Benefits to Eligible Employees, Eligible Dependents, and Eligible Retirees under age sixty-five (65). The dollar limits, Covered Expenses, and limitations are described below. If you have any questions about this benefit, you should contact the Plan Administrator.

Vision Benefits are not provided under the Plan’s Major Medical Benefit provisions. They are provided separately. If you have any questions about your Vision Benefits, please contact the Plan Administrator.

VISION BENEFIT

1. The two (2) consecutive Calendar Year maximum benefit for any Eligible Individual is $500. This benefit is paid at one hundred (100%) percent of Covered Expenses (as defined below). The maximum amount of the benefit available at any point during a two (2) consecutive Calendar Year period is equal to the two (2) consecutive Calendar Year maximum benefit reduced by the amount of vision expense benefits already provided during that period. Each two (2) Calendar Year period for purposes of calculating the maximum benefit will begin on January 1 of each even-numbered Calendar Year, commencing with January 1, 2008.

   This maximum dollar amount does not apply to eye examinations for Dependent children under nineteen (19) years of age.

   In no event are Vision Benefits available to an Eligible Retiree age sixty-five (65) and older.

COVERED EXPENSES
The following items are considered Covered Expenses under the Plan’s Vision Benefit provisions:

- Charges incurred for the services of Opthamologists (M.D.), or licensed Opticians.
The Reasonable and Customary charges incurred by the Eligible Individual for the services provided below:

1. Complete vision examination and expense as follows:
   a. Complete case history;
   b. Measuring and recording of visual acuity, corrected and uncorrected;
   c. Examination of fundis, medial rectus, crystalline lens, optic disk and pupil reflex for pathology;
   d. Anomalies or Injury;
   e. Corneal curvature measurements;
   f. Retinoscopy;
   g. Fusion determination, distance and near;
   h. Subjective determination, distance and near;
   i. Stereopsis determination, distance and near;
   j. Color discrimination;
   k. Amplitude of accommodation;
   l. Analysis of finding;
   m. Determining of prescription, if needed, or;
   n. Measuring and recording visual acuity, distance and near, with new prescription if required.

2. Prescription Lens and Frames as follows:
   a. Professional advice on frame selection;
   b. Facial measurements and preparation of specification for optical laboratory;
   c. Verifying and fitting of prescription glasses;
d. Verifying and fitting of prescription safety glasses for an Eligible Employee by a Plan approved Provider, or;

e. Re-evaluation and progress report two (2) to four (4) weeks after fitting of new prescription and subsequent servicing.

3. Sub-Normal Vision Care Benefit:

   a. If an Eligible Individual’s vision cannot be corrected to 20/70 in the better eye by use of conventional lenses, the following are Covered Expenses as Sub-Normal Vision Care, (provided vision is improved thereby up to 20/70):

      i. Contact lenses;

      ii. Telescopic lenses or other special vision aids, or;

      iii. Services required to fit, administer or otherwise prepare items in (i) or (ii) above.

   b. The Plan will pay one hundred (100%) percent of the eligible expenses incurred up to a maximum amount payable of $500 per Eligible Individual during each two (2) Calendar Year benefit periods for Sub-Normal Vision Care.

4. Surgical Vision Correction Benefit:

   a. An Eligible Individual may apply the two (2) consecutive Calendar Year annual maximum benefit to payment of Reasonable and Customary charges for surgical vision correction (radial keratotomy, LASIK, or the equivalent).

   b. The Plan has contracted with the QualSight network for discounted costs for surgical vision correction. You may save money by using a network provider for these services. Contact QualSight at (855) 800-2020.

EXCLUSIONS AND LIMITATIONS

Charges for the following services and supplies are not covered under the Vision Benefit:

1. Charges for, including, but not limited to, vision examinations, eyeglass frames, and eyeglass lenses, which exceed the two (2) consecutive Calendar Year maximum benefit in any two (2) consecutive Calendar Year period;
2. Any loss or expense caused by, incurred for, or resulting from:
   a. Procedures or supplies furnished on account of visual defect which arises out of, or in the course of any occupation for wage or profit;
   b. Declared or undeclared war, or any act of such war, or military or naval service of any country except as provided under the Plan's "Eligibility During Periods of Military Service" provisions;
   c. Vision care services or supplies which are payable or furnished by any other group policy or prepayment plan except private policies;
   d. Vision care services or supplies received from a medical department maintained by the policy-holder, a mutual benefit association, labor union, trustee, or other similar group;
   e. Plain sunglasses or goggles;
   f. Safety glasses (except prescription safety glasses for an Eligible Employee);
   g. Orthoptics, vision training or aniseikonia, or;
   h. Services or supplies for which the Eligible Employee or Dependent is not required to pay.
DENTAL BENEFITS

This Plan also includes a Dental Preferred Provider Organization (dental PPO), which is a network of Dentists and dental clinics that have a contract with the Plan to provide discounted dental services. You and your Beneficiaries will be issued a membership card, and without charge, a directory listing the dental clinics which are part of the network. The Plan has contracted to use the Delta Dental Network. If you have any questions about whether a particular Dentist you would like to see is a member of the network, contact the Plan Administrator.

You must present your ID card whenever you see a Dentist that is a member of the Network. In addition, you must refer to the Plan’s group number, which is 296.

You have complete freedom to see any Dentist that you wish. Even so, there are advantages to seeing an In-Network provider. If you see an In-Network provider, the Plan will pay the rate it has contracted with Delta Dental for the particular procedure, and you will receive the benefit of the discounts for any amounts you are required to pay. If you see an Out-of-Network provider, the Plan will pay the Reasonable and Customary Charge for the procedure, and you may be required to pay any remaining balance that is not covered by the Plan.

Dental Benefits are not provided under the Plan’s Major Medical Benefit provisions. They are provided separately. If you have any questions about your Dental Benefits, please contact the Plan Administrator.

SUMMARY OF DENTAL BENEFITS

Your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by the Plan is different for In-Network Dentists and Out-of-Network Dentists. If you see an Out-of-Network Dentist, your out-of-pocket expenses may increase.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Service</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>80%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>80%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80%</td>
</tr>
<tr>
<td>Major Restorative Services</td>
<td>80%</td>
</tr>
<tr>
<td>Prosthetic Repairs and Adjustments</td>
<td>50%</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>70%</td>
</tr>
</tbody>
</table>

Items covered under these headings are described below.
PLAN PAYMENTS

Claim Payments
Payments are made by the Plan only after the covered dental procedures have been completed. A claim submitted by an In-Network Dentist is paid at the rate that the Plan has contracted with Delta Dental for the particular procedure, up to the Plan’s maximum benefit, and you will receive the benefit of the discounts for any amounts you are required to pay. If, on the other hand, a claim is submitted by an Out-of-Network Dentist, the Plan will pay the Reasonable and Customary Charge for the particular procedure, up to the Plan’s maximum benefit, and the Dentist will be able to balance bill you for any charges not covered by the Plan.

Procedure for Submitting Claims
All claims should be submitted to the Plan Administrator. If you have any questions regarding the payment of dental expenses or eligibility for benefits, contact the Plan Administrator.

Prestatement of Costs - Estimate of Benefits
1. If your dental treatment involves major restorative periodontics, prosthetics or orthodontic care (see Description of Covered Procedures), a prestatement of costs must be submitted to the Plan Administrator prior to treatment.

2. After the examination, your Dentist will establish the dental treatment to be performed. If the necessary dental treatment involves major restorative, periodontics, prosthetics or orthodontic care, a participating Dentist will submit a claim form to the Plan Administrator outlining the proposed treatment. The Plan Administrator will determine if the proposed treatment is covered by the Program and will estimate the amount of payment.

3. A statement will be sent to your Dentist estimating the amount of the payment obligation and the amount you will owe. These estimates will be subject to your continuing eligibility for Dental Benefits under the Plan and to the continued effectiveness of the group dental plan contract. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce the Plan’s estimated payment for the proposed treatment and increase your obligation to the Dentist.

4. If your Dentist does not submit a prestatement of costs prior to performing the treatment, you will be responsible for payment of any dental treatment not approved by the Plan.
5. Cancellation and Renewal

   a. The Plan may cancel the dental program only on an anniversary date of the group dental plan contract with the dental PPO. The dental PPO may cancel the dental program if the group fails to make the required payments or otherwise breaches the terms of the group dental plan contract.

   b. Upon cancellation of the dental program, individuals otherwise covered under the program will have no right to continue coverage and no right to convert the group dental plan contract into an individual dental plan contract.

Benefit Maximums

The Plan pays up to a maximum of $2,400 for each Eligible Individual per Coverage Period, as defined below, for the following benefits: (1) Diagnostic and Preventative Services, (2) Basic Services, (3) Endodontics, (4) Periodontics, (5) Oral Surgery, (6) Major Restorative Services, (7) Prosthetic Repairs, and (8) Adjustments and Prosthetics. Orthodontics is subject to a separate lifetime maximum of $1,500 per Eligible Individual.

These maximums do not apply to the following Dental Benefits for Dependent children under age nineteen (19): (i) routine dental examinations; (ii) sealants; (iii) dental prophylaxis; and (iv) topical fluoride treatments.

Deductible

There is no deductible applicable to the Dental Benefit

Coverage Period

Each two (2) consecutive Calendar Year period for purposes of calculating the maximum benefit will begin on January 1 of each even-numbered Calendar Year, commencing January 1, 2010.

DESCRIPTION OF COVERED PROCEDURES

The Plan covers the following dental procedures when they are performed by a Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Plan will be provided whether the dental procedures are performed by a Physician or a Dentist, if otherwise covered under this Plan, provided that the dental procedures can be lawfully performed within the scope of a Dentist’s license.

Before approving claim payments, the Plan will be entitled to request and receive, from any attending or examining Dentist or from hospitals in which a Dentist's care is provided, the information and records relating to an Eligible Individual as needed to pay
claims. Also, the Plan may require that an Eligible Individual be examined by a dental consultant retained by the Plan in or near the Eligible Individual's place of residence. The Plan will keep the information and records confidential.

Only those services listed in the following provisions are covered. They are all subject to the Plan's maximum for Dental Benefits and the Exclusions from Coverage, below.

**Diagnostic and Preventive Services**

The following procedures are provided under this coverage:

1. Oral examinations twice per Calendar Year, including bitewing x-rays at twelve (12) month period.

2. Full mouth x-rays or panorex once in any three (3) year interval.

3. Dental or periodontal prophylaxis (cleaning of the teeth) as prescribed by the Dentist, but not more than twice per Calendar Year.

4. Topical fluoride applications as prescribed by the Dentist, but not more than once in any twelve (12) month period.

5. Oral hygiene instruction as prescribed by the Dentist, but not more than once per lifetime for each Eligible Individual.

6. Space maintainers for extracted posterior primary teeth on covered Dependent children.

**Basic Services**

The following procedures are provided under this coverage:

1. Emergency treatment for relief of pain (minor procedures).

2. Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver fillings), preformed crowns for Dependent children, or resin (white fillings) restorations on anterior teeth.

3. Sealants - Coverage limited to once per lifetime for permanent first and second molars of eligible Dependent Children under the age of sixteen (16) years.

**Endodontics**

This coverage includes pulpotomies on primary teeth for Dependent children and root canal therapy on permanent teeth. No coverage is provided for retreatment.
Periodontics
The following procedures are provided under this coverage:


   LIMITATION: Benefit for the repeat of any nonsurgical periodontal treatment will be provided only after a two (2) year period has elapsed.

2. Surgical periodontics: The surgical procedures necessary for the treatment of diseases of the gingiva (gums) and bone supporting the teeth.

   LIMITATION: Benefit for the repeat of any surgical periodontal treatment will be provided only after a three (3) year period has elapsed. Procedures designed to enable prosthetic or restorative service to be performed, such as crown lengthening, are not covered benefits.

Oral Surgery
The following procedures are provided:

1. Routine oral surgery, provides for tooth removal (including alveolectomy, where indicated), including pre- and post-operative care.

2. All other oral surgery such as alveoloplasty, vestibuloplasty, removal of cysts, tumors, growths, neoplasms, and treatment of compound and simple fractures.

3. Surgical and nonsurgical treatment of temporomandibular joint disorder (TMD) and craniomandibular disorder pursuant to Minnesota Statutes Section 62A.043 Subd. 3, subject to the provisions of Coordination of Benefits below.

Major Restorative Services
The following procedures are provided under this benefit:

1. Special restorative procedures to restore lost tooth structure as a result of tooth decay or fracture.

2. Crown, inlays or onlays when the amount of lost tooth structure does not enable the placement of a filling material. If inlays are placed, benefits will be limited to the same number of surfaces and allowances for amalgam (silver filling).
3. Resin (white filling) restorations for posterior teeth. Posterior teeth will have a resin restoration maximum of three (3) surfaces."

Prosthetic Repairs and Adjustments
This coverage provides for the coverage of prosthetics and of repairs and adjustments to a prosthetic serving as a permanent prosthetic appliance.

Prosthetics: Removable and Fixed

1. Prosthetics: Provides bridges, standard partial dentures and full dentures for the replacement of fully extracted permanent teeth. Benefits are limited to the commonly performed method of tooth replacement.

   **EXCLUSION:** Coverage is NOT provided for the replacement of teeth congenitally missing.

2. Replacement benefits for a given prosthetic appliance for the purpose of replacing an existing appliance will be provided only if the existing appliance is not, and cannot be made satisfactory.

   **EXCLUSION:** Coverage is NOT provided for the replacement of misplaced, lost, or stolen dental prosthetic dental appliances.

3. Services which are necessary to make an appliance satisfactory will be provided."

Orthodontics
The following procedures are provided under this coverage:

1. Orthodontic Care: Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies for all Eligible Individuals.

   **LIMITATION:** Coverage is not provided for expenses for treatment of an Eligible Dependent incurred on or after the Eligible Dependent spouse’s 19th birthday, or on or after the Eligible Dependent child’s 26th birthday.

   **EXCLUSION:** Coverage is NOT provided for the repair or replacement of any orthodontic appliance (fixed or removable), splint or occlusal guard. See List of Exclusions and Limitations. Note: Orthodontic retainers (fixed or removable) are considered part of the complete treatment and so are included in the total fee for the case.
EXCLUSIONS FROM COVERAGE

Coverage is NOT provided for:

1. Dental procedures performed for purely cosmetic purposes.
2. Charges for dental procedures which were completed prior to the date the Eligible Individual became eligible for coverage under the Group Dental Plan Contract.
3. Services of anesthesiologists.
4. Charges for any dental procedures or health care services not specifically covered under the Group Dental Plan Contract (including any Hospital charges or prescription drug charges). New or experimental dental techniques or procedures may be denied until there is, to the satisfaction of the Trustees, an established scientific basis for recommendation.
5. Dental procedures performed other than by a licensed Dentist and his or her employees or agents.
6. Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: Increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting and gnathologic recordings.
7. Direct diagnostic, surgical or nonsurgical treatment procedures applied to body joints or muscles; except as provided under Orthodontics or Oral Surgery provisions above.
8. Any artificial material implanted into or onto bone or soft tissue including implant procedures and associated fixtures, or surgical removal of implants.
9. Veneers (bonding of coverings to the teeth).
10. Orthodontic treatment procedures, unless specified in this document as a covered Dental Benefit.
11. Consultations and office visits.
12. Temporary procedures.
13. Athletic mouth guards.
14. Coverage is not provided for retreatment or additional treatment necessary to correct or relieve the results of previous treatment.

15. Removable unilateral dentures.

16. In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed will be solely that of the Eligible Individual and the Dentist; however, the benefits payable under this Plan will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Eligible Individual.

17. Charges for special nursing, Dentists or other specialists.

18. Charges incurred in connection with treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar process, oral surgery, except as specifically provided.

19. Charges incurred for dental implants, unless the Eligible Individual receives the dental implants in lieu of another dental procedure, appliance, or restoration. In those cases, the Plan will pay for charges up to the maximum amount that the Plan otherwise would have covered for the dental procedure, appliance or restoration the Eligible Individual chose dental implants in lieu of. The Eligible Individual will be responsible for any remaining charges or expenses in excess of what the Plan covered.
PRESCRIPTION DRUG BENEFIT

SUMMARY

The Plan provides Prescription Drug Benefits to Eligible Individuals and their Beneficiaries. Prescription Drug Benefits are not provided under the Plan’s Major Medical Benefit provisions. They are provided separately. If you have any questions about your Prescription Drug Benefits, please contact the Plan Administrator.

PRESCRIPTION DRUG BENEFITS

The Plan has a contract with Medco Health Solutions, Inc. Pharmacy Network (“Network”) to provide prescription drugs at discounted prices. This contract includes coverage for injectibles and specialty drugs, which are covered only if purchased through Medco Health Solutions, Inc.

If you use a provider in the Network, the provider will automatically file a claim with the Plan Administrator for you. When you visit an In-Network pharmacy, you will need to show them your Plan prescription identity card. Under the Prescription Drug Benefit, you will be able to purchase up to a 90-day supply of prescription drugs. For specialty drugs, you must obtain them through a specialty drug provider in the Medco Pharmacy Network.

If you would like to find out if a particular pharmacy is part of the Medco Pharmacy Network, call (800) 711-0923, or you can also search Medco’s Website at http://www.medco.com.

If you do not use a provider in the Network, you must pay the full price of the prescription up front and request reimbursement by filing the claim with the Plan Administrator yourself. You will not benefit from any discounts negotiated by the Plan with providers in the Network. You may obtain the required paper claim forms by contacting Medco at the number provided above or on Medco’s Website.

In addition, if you would like to take advantage of the Plan’s mail order prescription benefit, contact Medco for an application form.

PLAN BENEFITS PAID

The Plan will pay ninety (90%) percent of Covered Expenses for generic prescription drugs and eighty (80%) percent of Covered Expenses for brand name prescription drugs. The remaining percentage is known as “co-insurance”, which you must pay out-of-pocket until you reach the maximum out-of-pocket expense limit for Prescription Drug Benefits as specified on the Summary of Benefits. The coinsurance amount will never
be less than $5 and will count only towards satisfying the out-of-pocket maximum for Prescription Drug Benefits, and will not count towards satisfying any out-of-pocket maximum for Major Medical Benefits.

Prescription Drug Benefits are not subject to any deductible.

**EXCLUSIONS AND LIMITATIONS**

No payment will be made for any loss, expense, or charge incurred for:

1. Drugs or medicines which are available as over-the-counter purchases, such as aspirin, cough medicine, or vitamin supplements (including pre-natal vitamins), regardless of whether recommended or prescribed by a Physician.

2. Cosmetic drugs, such as Renova or Propecia.

3. Patent medicines or drugs, or medicines not legally dispensed by a registered pharmacist according to the written prescription of a Physician.

4. Drugs or medicines which are Experimental or Investigative; are used in clinical trials or research; are not widely accepted and used by the medical community; or which have not been approved for general sale and distribution by the U.S. Food and Drug Administration (“FDA”). Although some uses of a drug may be non-Experimental or non-Investigative or approved by the FDA, drugs or medicines prescribed for a particular use that is not approved by the FDA are excluded.

5. Any expense whatsoever under the Prescription Drug Benefit where payment would exceed a benefit limit or maximum set forth in the Summary of Benefits.

6. Any prescription drug expense if you are enrolled in the Medicare Part D prescription drug program and are covered under the Plan by reason other than active employment.

7. Any injectible or specialty drug not purchased through Medco Health Solutions, Inc.

*This list of exclusions and limitations is a representative and not an all-inclusive list of exclusions and limitations applicable to the Prescription Drug Benefit.*
HIGH-RISK INSURANCE POOL BENEFIT

SUMMARY

The Plan provides High-Risk Insurance Pool benefits to Eligible Individuals and their Beneficiaries. These benefits are not provided under the Plan’s Major Medical benefit provisions. They are provided separately. If you have any questions about them, please contact the Plan Administrator.

HIGH-RISK INSURANCE POOL BENEFIT

Many states sponsor high-risk insurance pools to attempt to fill the insurance gap for individuals who are denied health coverage due to their health and the high risk they pose to insurers. You might wish to consider looking into one of these pools if, for example, you have reached (or are about to reach) the lifetime major medical maximum benefit set forth on the Summary of Benefits at the beginning of this Plan document.

The eligibility rules, plan of benefits, and all other aspects of any high-risk insurance pool are distinct from the Plan. You alone would be responsible for identifying, applying for, qualifying for, and enrolling in a high-risk insurance pool.

However, an Eligible Individual will be eligible for the Plan’s High-Risk Insurance Pool Benefit if all of the following conditions are met:

- The Eligible Individual has reached the lifetime major medical maximum benefit set forth on the Summary of Benefits; and
- The Eligible Individual is enrolled in a high-risk insurance pool.

To claim the High-Risk Insurance Pool Benefit, an Eligible Individual must submit evidence to the Plan Administrator of the amounts the Eligible Individual has already actually paid for the following:

1. Premiums for coverage under a high-risk insurance pool;
2. Expenses that were applied against the deductible by that high-risk insurance pool, and;
3. Coinsurance and co-payments for expenses covered under that high-risk insurance pool.

The Trustees have the discretion to determine whether any such evidence is sufficient and to reject claims where the evidence is insufficient. Even so, canceled checks;
detailed, itemized receipts; and explanations of benefits that you provide may be helpful in making the determination.

The High-Risk Insurance Pool Benefit will take the form of payment directly from the Plan to you for the amount of the expenses described above, up to the limit set forth on the Summary of Benefits.
PLAN CONDITIONS, LIMITATIONS AND EXCLUSIONS

SUMMARY

This Plan is designed to pay for only certain types of benefits. This section contains a list of various conditions and exclusions which apply. The list is provided only as an example. There may be other exclusions, conditions, and limitations that apply. The Plan Administrator can provide you with more information.

No payment will be made under this Benefit Plan for any loss, expense or charge:

1. Incurred as the result of any accidental bodily Injury, Sickness, disease, mental or nervous disorder sustained while the individual was performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.

2. Incurred as the result of any accidental bodily Injury, Sickness, disease, mental or nervous disorder, which arises out of and in the course of any occupation or employment for wage or profit, or which may be payable in whole or in part under any workers' compensation law, employer's liability law, occupational diseases law or similar law. However, at the sole discretion of the Trustees, the Plan will consider advancing medical expenses payable in whole or in part under workers' compensation law provided that the Eligible Individual signs an acknowledgment of the Plan's first priority right to subrogation and reimbursement.

3. Incurred for services rendered while the individual is confined in a Hospital operated by the United States Government or an agency of the United States Government, provided, however, that if the charges are made by a Veterans Administration ("V.A.") hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law, and subject to all the requirements of this Plan, the charges will be considered Covered Medical Expenses.

4. Incurred for which the Eligible Individual is not legally required to pay.

5. Incurred for education, training, or Room and Board while the individual is confined in an institution which is primarily a school or other institution for learning or training.
6. Incurred while an individual is confined for purposes of Custodial Care in an institution which is primarily a place of rest, a place for the aged, or a nursing home.

7. Incurred for any type of Custodial Care (care that is designed primarily to assist an individual in meeting the activities of daily living, such as milieu therapy), regardless of what the care is called.

8. Incurred for any services or treatments not prescribed by a Physician. This exclusion applies to items such as vitamins, cough medicine, aspirin, cosmetics, soap, toothpaste, etc.

9. Incurred for any treatment, surgical procedure or service that is of an elective nature or for any non-emergency plastic or cosmetic surgery on the body, including, but not limited to, such areas as the eyelids, nose, face, breasts, or abdominal tissue.

**Exception:** This exclusion will not apply to:

a. Cosmetic surgery which is performed for the correction of defects incurred through traumatic injuries, infection, or other diseases of the involved part sustained by an individual;

b. The correction of congenital defects;

c. Corrective surgical procedures on organs of the body which perform or function improperly;

d. Vasectomies and tubal ligation procedures, except charges incurred for the reversal of vasectomy or a tubal ligation will not be covered; and

e. Surgery to reconstruct a breast following a mastectomy procedure on the affected breast and (1) any surgical procedure on the non-affected breast which is intended to provide a symmetrical appearance; (2) prostheses implants, and up to four (4) brassieres per Calendar Year following the mastectomy for simulating natural body contours; and (3) the treatment of any physical complications associated with the mastectomy procedure.

10. Incurred for medical and surgical treatment of weight-related disorders (such as obesity and morbid obesity) including, but not limited to, surgical interventions, dietary programs, prescription drugs, and related Physician visits, except as specifically stated in the “Covered Medical Expenses” section of this Plan document.
11. Incurred for any services or supplies which are not recommended or approved by the attending Physician.

12. Incurred for services or supplies received from a physician who does not meet this Plan's definition of a Physician or from a hospital which does not meet this Plan's definition of a Hospital.

13. Incurred for services, supplies, treatments, or procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational accidental bodily Injury or Sickness unless the charges are specifically identified as being Covered Expenses or Covered Medical Expenses under the Plan.

14. Incurred as a result of treatment or consultation with a marriage counselor, or as a result of treatment or consultation with a social worker, except as provided for in the Plan's Mental Health Expense Benefit provisions or the Plan's Family Assistance Program provisions.

15. [Reserved].

16. Incurred for physical therapy or any other type of therapy if either the prognosis or history of the individual receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of improvement, except for charges incurred which are covered as Hospice Care Expenses.

17. Incurred for any procedure, prescription, supply or device considered to be not in the best interest of the Eligible Individual and as approved by the Trustees.

18. Incurred for speech therapy, except when: (a) it is Medically Necessary because of physical impairment caused by disease or Injury, or (b) the charges are specifically identified as being Covered Medical Expenses for Developmental Delay Therapy Services.

19. Incurred for any special education rendered to any individual, regardless of the type of education and the purpose of the education, except for a single nutritional consultation session recommended by the attending Physician.

20. Incurred for radial keratotomy, eye exams, eye refractions, eyeglasses, or contact lenses except for the first pair of contact lenses required following cataract surgery, or dental prosthetic appliances, including any charges made for the fitting of any of these appliances, except when the service or supply was rendered as a result of non-occupational accidental bodily Injury; provided, the service or supply is made promptly following the
Injury and within twelve (12) months from the date of the Injury or when charges incurred for the service or supply are otherwise specified as payable under the provisions of this Plan.

21. Incurred for the completing of claim forms (or forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

22. Incurred for nursery care beyond the joint confinement of the mother and child or after the end of the period that either the mother or newborn child is no longer medically required to remain in the Hospital. In determining a mother’s maximum period of medically required confinement, the period of a normal maternity confinement will be used. In the event of termination of nursery charges for a newborn child, benefits will be payable for the newborn child only if all other eligibility rules of the Plan have been met for such child.

23. Incurred for contraception or birth control other than (a) covered surgical sterilization and (b) oral contraceptive or other medications prescribed by a Physician.

24. Incurred by Dependent children for vasectomies or other sterilization procedures unless recommended by a Physician for therapeutic purposes of the patient.

25. Incurred for any operation or treatment in connection with sex transformations.

26. Incurred to treat Sicknesses or Injuries incurred in, or aggravated during, performance of service with the uniformed services; except as may otherwise be provided for under this Plan.

27. Incurred for dental services and supplies rendered for treatment of the teeth, the gingiva/gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, except when the charges are for services rendered for the repair of accidental Injury to sound natural teeth or are otherwise specified as payable under the provisions of this Plan.

28. Incurred for travel, whether or not recommended by a Physician, except as specified in the "Covered Medical Expenses" provisions of this Plan.
29. Incurred for physical, occupational, and speech therapy for treatment of an individual diagnosed as developmentally delayed, except for those specifically covered as Developmental Delay Therapy Services under this Plan.

30. Incurred for services, supplies or procedures that are Experimental or Investigative in nature. Although some uses of a treatment may be non-Experimental or non-Investigative or are approved by the Food and Drug Administration, a particular use which is Experimental or Investigative or which is not approved by the Food and Drug Administration is excluded. Furthermore, treatments that relate to Experimental or Investigative treatments or to treatments not approved by the Food and Drug Administration which would not be performed but for the excluded treatment are excluded. Any medical or surgical complications resulting from excluded treatments are also excluded.

31. Incurred where payment would exceed a benefit limit or maximum set forth on the Summary of Benefits, except as governed by any applicable restoration, reinstatement, or extension of benefits provision.

32. Incurred for any treatment, care, procedures, services or supplies which are not Medically Necessary, except where this Plan specifically provides otherwise (that is, routine physical examinations, routine immunizations, and colorectal cancer screenings).

33. Any amount of an incurred charge that is determined to be in excess of a Reasonable and Customary Charge.

34. Incurred for the rental or purchase of any durable medical equipment or other equipment that is: (a) not used solely for therapeutic treatment of a single individual's Injury or Sickness; (b) a duplicate or near-duplicate of any such equipment currently rented or already purchased (such as a manual wheelchair when a power wheelchair is currently rented or was already purchased or such as a second CPAP machine), as well as any rental charges for durable medical equipment in excess of the purchase price of the item rented; or (c) otherwise in excess of the limitations on coverage as explained in “Other Major Medical Benefits.”

35. Incurred for any of the following list of items, regardless of intended use, including, but not limited to: air conditioners, air purifiers, whirlpools, swimming pools, humidifiers, de-humidifiers, allergy-free pillows, blankets or mattress covers, electric heating units, orthopedic mattresses, exercising equipment, gravity lumbar reduction chairs, vibratory equipment, pre-fabricated orthotic devices, elevators or stair lifts, stethoscopes, clinical thermometers, scales, articles of clothing, and shoes (including orthopedic shoes), except for elastic bandages or
stockings, wigs, and devices or surgical implantations simulating natural body contours as specified in this Plan.

36. Incurred for any in-Hospital items such as telephones, televisions, cosmetics, magazines, newspapers, laundry, guest trays, or beds or cots for guests or other family members, or any other personal comfort items or items that are not Medically Necessary.

37. Incurred for Hospice Care, except as provided under the Plan’s Hospice Care Benefit.

38. Incurred for any confinement in a nursing facility other than as provided under this Plan.

39. Incurred for patent medicines or drugs, or medicines not legally dispensed by a registered pharmacist according to the written prescription of a Physician.

40. Incurred for any type of service or supply provided in connection with tobacco use cessation.

41. Incurred for a hypnosis.

42. [Reserved]

43. Incurred for confinement and services at a halfway house or group home.

44. Charges that would not have been made if this Plan did not exist.

45. Incurred in connection with any Injury or Sickness for which the individual is not under the regular care of a Physician.

46. Hospital charges incurred in connection with an in-patient Hospital confinement for the purpose of dental treatment for which there exists no written certification by an M.D. that the in-patient confinement is Medically Necessary for such treatment.

47. Drugs or medicines prescribed by a Physician which are available as over-the-counter purchases, e.g., aspirin, cough medicine, or vitamin supplements.

48. Any loss, expense or charge for Sickness or Injury resulting from engaging in an illegal act. "Illegal act" will mean any illegal occupation or conduct that constitutes a gross misdemeanor or felony offense under the laws in the State of Minnesota, or equivalent laws of the state in which the occupation or conduct occurred, and for which the Eligible Individual is or
may be charged. If the Eligible Individual is not convicted of the gross misdemeanor or felony (or equivalent offense) at the conclusion of the matter, the claims for the loss, expense or charge may be resubmitted to the Plan for consideration and review; provided that, the claim had previously been submitted to the Plan for consideration within the time period permitted for the timely submission of claims under the Plan. Subject to the other limitations and exclusions provided in this document, the Plan may cover any loss, expense or charge related to an act of domestic violence committed against the Eligible Individual, or if the illegal act is related to a physical or mental health condition of the Eligible Individual.

49. Charges or benefits that are provided for or paid for by a program of the Federal, State, or City Government, including Medicare, TRICARE, Medicaid, and statutory disability benefits.

50. Charges for any Injury or condition that results from an incident occurring on any property where the lessee or lessor or owner of the property is responsible for Injury or Sickness or which is otherwise covered under homeowner’s insurance or premises liability insurance. However, at the sole discretion of the Trustees, the Plan will consider advancing payment of the charges only if: (a) no insurance or other form of compensation is available to the victim, and (b) the Eligible Employee and/or Eligible Dependent (the individual responsible for payment of expenses) signs an acknowledgment of the Plan’s first priority right to subrogation and reimbursement.

51. Any loss, expense or charge incurred as a result of any automobile accident, or the use or maintenance of an automobile:
   a. Where the Eligible Individual fails to maintain the statutory minimum level of no-fault automobile medical insurance protection, provided that the Eligible Individual is required by the state law to maintain the protection in the jurisdiction in which the Eligible Individual resides (the exclusion under this paragraph (a) will apply only up to the amount of the automobile medical and/or disability insurance so required);
   b. Where there is applicable no-fault coverage but the Eligible Individual has failed to apply for the coverage;
   c. Where a no-fault insurer has determined charges not to be Medically Necessary or Reasonable and Customary; or
d. In states without a no-fault statute, where the Eligible Individual does not first exhaust medical payment coverage on the vehicle(s) involved in the accident.

In cases where a no-fault carrier disputes coverage of the Eligible Individual, the Plan may subrogate its interest in the payment of charges. Please also refer to the “Coordination of Benefits with Automobile Insurance” section of this Plan of Benefits regarding when an individual injured in an automobile accident must arbitrate before the Plan will pay benefits related to the accident.

52. Charges incurred in connection with acupuncture unless performed by a Doctor of Medicine (M.D.).

53. Charges for injections prescribed or administered by a Doctor of Chiropractic (D.C.).

54. Charges incurred for the treatment of compulsive gambling except as offered through the Plan’s Family Assistance Program.

55. Charges for or related to membership in a health or fitness club/facility, work-hardening program, therapeutic exercise programs, and all related materials and products related to these programs.

56. Charges for or related to genetic engineering and testing except as specifically provided for by the Plan.

57. Charges for special home construction to accommodate a disabled individual.

58. Charges for telephone conversations/telephone consultations.

59. Any loss, expense, or charge for which a Third Party may be liable for which the individual on whose behalf the claim was filed did not submit the required subrogation agreement to the Plan. The term “Third Party,” as used in these “Plan Conditions, Limitations, and Exclusions”, will include any individual, insurer, entity, or federal, state or local government agency who is or may be in any way legally obligated to reimburse, compensate or pay for an individual’s losses, damages, injuries, or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Plan’s provision of medical, dental or disability benefits, including, but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist, or underinsured motorist coverages.

60. Any loss, expense or charge for which a Third Party may be liable and for which either: (a) a recovery subject to the Plan’s subrogation and
reimbursement rights has been received (whether before or after the submission of or payment of claims by the Plan), or (b) the Trustees deem it likely that recovery will be received. At the discretion of the Trustees, losses, expenses, and charges excluded by this paragraph may be paid subject to the Plan’s right of subrogation and reimbursement. The Eligible Individual for which payment of claims is sought must sign an acknowledgment of the Plan’s first priority right to subrogation and reimbursement before the Plan will advance payment of benefits for related claims.

61. Any losses incurred by an individual at a time that the individual owes a premium payment to the Plan, or any losses incurred by an individual who performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact in connection with coverage under this Plan.

62. Any loss, expense, or charge incurred as the result of any Injury, occurrence, condition or circumstance for which the injured individual:
   a. has the right to recover payment from a Third Party. At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan’s right of subrogation and reimbursement. The Eligible Individual for which payment of claims is sought must sign an acknowledgment of the Plan’s first priority right to subrogation and reimbursement before the Plan will advance payment of benefits for related claims;
   b. has recovered from a Third Party; or
   c. has not submitted a claim for the loss, expense or charge prior to resolution of the Third Party claim.

63. Incurred for services otherwise covered by Medicare but which are instead provided under a private contract, except to the extent the amount incurred for the services would have been payable by the Plan had the services been payable by Medicare.

64. Incurred at any time as the result of a Sickness or Injury that is or would be subject to the Plan’s right of subrogation and reimbursement and either: (1) as to which the Plan has agreed to a settlement of that right, or (2) the Eligible Individual has recovered payment from a Third Party, (3) the Eligible Individual has received a recovery from a Third Party, or (4) would otherwise, in the sole discretion of the Trustees, be considered a future related medical expense, even if incurred but not paid before the settlement, unless the Trustees have explicitly agreed in writing that the Plan will pay for such a loss, expense, or charge. This means that claims
submitted after the settlement or recovery that are, in the sole discretion of
the Trustees, related to the Sickness or Injury giving rise to the settlement
or recovery will be excluded from coverage under this Plan. This
exclusion applies to any recovery received by the Eligible Individual
regardless of how it is characterized, including but not limited to, any
apportionment to a spouse for loss of consortium.

65. All enteral and parenteral feedings and other feedings and other
nutritional and electrolyte supplements or formula (including
intraperitoneal nutrition and intradialytic parenteral nutrition therapy),
except for enteral nutrition therapy, parenteral nutrition therapy, and
nutrition supplementation (other than intradialytic parenteral nutrition
therapy or intraperitoneal therapy) as prescribed by a Physician as an
accepted treatment for an Injury or Sickness.

66. Jobs stockings in excess of four (4) per Calendar Year.

67. Court-ordered treatment or confinement of any kind, except as specified
in the Mental Health Expense Benefit.

68. Shipping and handling for charges incurred on Covered Expenses.

69. Magnetic devices.

70. Allergy food drops, sublingual allergy drops, or oral immunotherapy.

71. Prophylactic surgery, except as specified in the Prophylactic Mastectomy
Benefit.

72. Orthodontics, except as specified in the Dental Benefit.

73. Dental treatment including, but not limited to, dental implants, except as
specified in the Dental Benefit or in the description of Covered Medical
Expenses.

74. Massage Therapy, except as provided by a licensed physical therapist.

75. Chelation therapy, except in cases of heavy metal poisoning.

76. Any claim for a loss, expense, or charge submitted to the Plan on behalf of
an individual that is fraudulently submitted or involves an intentional
misrepresentation of material fact.

The above listing is not an all-inclusive listing of services, expenses or charges not
covered by the Plan. It is only representative of the types of services and supplies for
which no payment is made by the Plan.
RETIREE BENEFITS: “THE SENIOR PLAN”

SUMMARY

Retiree Benefits are an important part of your fringe benefit package. The cost of providing those benefits, like all medical costs, has risen dramatically over the last few years. In the future, these benefits may need to be altered in order to maintain the financial integrity of the Plan. Your contributions for coverage under the “Senior Plan” must be made in accordance with the Plan provisions on payment of Self-Contributions for Retiree Benefits.

This Section of the Plan specifically states that Retiree Benefits and the rates charged for those benefits are not guaranteed. The Trustees may alter, amend, or discontinue the retiree program at any time, at their discretion.

As an Eligible Individual in the “Senior Plan”, you and your Dependents are entitled to most of the benefits provided by the Plan in the same manner as any other Eligible Individual in the Plan. Upon your election to participate in the “Senior Plan”, you may also choose to continue to participate in the Plan’s “Dental Benefit” provisions (see “Election of Dental Coverage” under the section entitled “Continued Eligibility While Retired” for a description of the rules regarding the election of coverage). There are, however, some exceptions to this general rule, which are described below.

If you have any questions regarding the benefits available to Eligible Individuals in the “Senior Plan,” please contact the Plan Administrator.

Eligible Individuals in the “Senior Plan” under 65 Years of Age

If you are an Eligible Individual in the “Senior Plan” and are under sixty-five (65) years of age, you are entitled to all benefits provided under the Plan to all other Eligible Individuals except for the following:

- Weekly Disability Benefit;
- Accidental Death and Dismemberment; and
- Life Benefit above $2,000 ($15,000 for active Employees).

Eligible Individuals in the “Senior Plan” age 65 and above

In addition to the benefits excluded for Eligible Individuals in the “Senior Plan” under sixty-five (65) years of age, if you are sixty-five (65) or older you will not be entitled to the Plan’s Vision Benefit, Hearing Aid Benefit, or Prescription Drug Benefit if enrolled in the Medicare Part D prescription drug program.
PAYMENT OF BENEFITS

SUMMARY

The next few sections of the document describe many general rules that apply to all types of benefits you may receive under the Plan. Some of the more important rules are listed below.

- The Trustees of the Plan, or anyone they may delegate, have the sole authority to interpret this document, and any other documents concerning the Plan.

- Similarly, the Trustees may amend or modify the Plan at any time. No benefits or conditions of the Plan are promised or guaranteed to continue.

- Your claims for benefits must be filed within certain time limits described in these sections.

- If someone else is legally responsible to pay for an Injury they have caused you, the Plan may recover the amount of benefits it has paid as a result of that Injury. The Plan’s right to so recover is known as the right of “subrogation.”

Quite often an individual may be covered under more than one (1) health care plan. For instance, a husband may be covered under this Plan as an Employee, and covered under his wife’s plan as a dependent. The Trustees of this Plan have adopted rules that determine which plan(s) must pay for benefits and in what order. Those “Coordination of Benefits Rules” are described in this section.

This section of the document also describes the claims appeal procedures that you and the Trustees must follow if your claim for benefits is partially or totally denied. You may appeal a denial to the Board of Trustees.

RULES GOVERNING PAYMENT OF BENEFITS

The following rules affect the payment of benefits from this Plan:

- Benefits payable for any loss will be paid upon timely receipt by the Trustees, or their duly appointed representatives, of written proof of loss covering the occurrence, character, and extent of the event for which claim is made.
Benefits are payable to the Eligible Employee or Eligible Retiree whose Injury or Sickness, or whose Eligible Dependent's Injury or Sickness, is the basis of claim under this Plan, unless benefits are assigned according to the provisions described below. Even so, payments for services furnished to a Dependent child whose parents are divorced and who is not a member of the Employee's or Retiree's household may be paid directly to the service provider(s), at the discretion of the Plan Administrator, whether or not benefits are assigned.

The provisions governing assignments will be:

1. No assignment of any present or future right, interest, or benefit under this Plan will bind the Trustees without their written consent.

2. Assignment of Hospital expenses and expenses for medical care and treatment will be automatic when care is provided through a PPO, and no assignment will be required to be signed by the Employee or Retiree.

3. The Trustees may, at their option, accept validly executed assignments of benefits made by the Eligible Employee or the Eligible Retiree when the assignments are executed in favor of any other provider of medical services providing medical services that are covered by this Plan. In that case, benefits will be paid to the assignee instead of to the Employee or Retiree.

4. Assignments made by an Eligible Employee's spouse or an Eligible Retiree's spouse will be considered valid assignments.

5. No assignment of benefits will assign more than the assignor's right to payment of benefits and will not be deemed to assign any other right or interest that the assignor has under the Plan, including, but not limited to, the right to appeal or seek review of a benefit denial.

6. Except as otherwise prescribed by law, no payments will be subject to the debts, contracts, or engagements of any Eligible Individual, or to any judicial process to levy upon or attach benefits for payment of an Eligible Individual's debts.

7. Any unpaid medical benefits due and owing at the time of the Employee's death may be paid, at the Plan's option, to a Beneficiary or the Employee's estate.

Subject to proof of loss, benefits payable for any loss for which this Plan provides periodic payments will be paid not less often than semi monthly during the continuance of the period for which there is coverage and any
balance remaining unpaid upon termination of coverage under the Plan will be paid immediately upon receipt of proof of loss.

- If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for the individual, the Trustees may, at their option, assign benefits to the provider(s). That assignment will constitute a complete discharge of the Plan's obligations to provide benefits.

- A charge for any service, supply, or treatment will be considered to have been incurred on the date the service or treatment was rendered or the supply provided.

- Benefits will be payable by the Plan up to but not to exceed any Maximum Benefit or other benefit limitation specified on the Summary of Benefits. For each Eligible Individual, whether or not there has been an interruption in the continuity of eligibility, the maximum amount of benefits available during any specified period of time will be equal to the amount by which the Maximum Benefit specified for that period of time exceeds the sum of the benefits previously paid or provided on the Eligible Employee’s account during that period of time.

- Benefits will be payable only for expenses incurred by individuals who are Covered Under The Plan at the time the expenses are incurred.

- Benefits will be payable for expenses incurred by an Eligible Individual only if the expenses are incurred within any applicable time limitations specified on the Summary of Benefits or in any other applicable provision of this Plan of Benefits.

- Benefits will be payable only for expenses which are specified as Covered Expenses or Covered Medical Expenses or which are specified as payable in any other applicable provision of this Plan, subject to any applicable limitations or exclusions.

- Medical benefits will be payable only for expenses incurred as the result of care and treatment provided to an Eligible Individual solely as the result of a non occupational Injury or Sickness unless a particular type of expense which would normally be excluded by this provision is specifically included as a Covered Expense or is specified as payable in any other applicable provision of this Plan of Benefits.

- Medical benefits will be payable only for expenses which are Medically Necessary and which are required in connection with the care and treatment of an Eligible Individual as a result of non occupational Injury or Sickness.
Medical benefits will be payable only for expenses which are incurred upon the recommendation of, or with the approval of, a Physician who is acting within the scope of the Physician's license.

Benefits will be payable only for expenses which are actually incurred.

The self funded (self insured) benefits payable under this Plan are limited to the Plan assets available for those purposes regardless of accumulated eligibility.

Expenses incurred by a female Employee, by a female Retiree, by a Dependent spouse of a male Employee, by a Dependent spouse of a male Retiree, or by a female Dependent Child of an Employee as the result of a pregnancy or a pregnancy related condition will be treated the same as expenses incurred for a Sickness or non occupational Injury. Payment for the expenses will be made according to the provisions and conditions of each benefit.

For benefits charges incurred with participating providers, the Plan will pay a discounted amount. These providers have agreed to accept payment from the Plan as payment in full, except for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan.

For benefits charges incurred with non-participating providers within the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network, the Plan will pay the Reasonable and Customary charge, or if applicable, a negotiated charge to the non-participating provider. You will be responsible for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan.

Benefits charges incurred with non-participating providers outside the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network, will come through the Blue Cross Blue Shield Blue Card System. The Plan will pay the Reasonable and Customary charge as provided by the Host Plan with the Blue Card System or, if applicable, a negotiated charge separately negotiated with the non-participating provider. You will be responsible for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan.

Any payments made by the Trustees according to these provisions will fully discharge the liability of the Trustees to the extent of such payment. Other provisions governing the payment of benefits and/or the limiting or exclusion of benefits are specifically set forth in the various provisions of this Plan of Benefits.
There are conditions, limitations and exclusions which apply to certain types of charges. Refer to the "Plan Conditions, Limitations and Exclusions" section of this document for more information. You will also want to check the "Definitions" section which defines important terms of the Plan.

**Payments to those Eligible for Medical Assistance**

Payment of benefits under the Plan with respect to any Eligible Individual in the Plan will be made according to any assignment of rights made by or on behalf of the Eligible Individual or a Beneficiary of the Eligible Individual as required by any applicable state plan for medical assistance which is approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of the Act. In enrolling an individual as an Eligible Individual or Beneficiary or in determining or making any payment of benefits for or on behalf of an individual as an Eligible Individual or Beneficiary in the Plan, the Plan will not take into account the fact that the individual is eligible for or is provided medical assistance under an applicable state plan for medical assistance which has been approved under Title XIX of the Social Security Act. In any case in which the Plan has a legal liability to make payments of benefits for or on behalf of an Eligible Individual or Beneficiary for items or services as to which payment has legally been made under any applicable state plan for medical assistance approved under Title XIX of the Social Security Act, the payment by the Plan will be made according to any applicable state law which provides that the state has acquired a right to payment for the items or services with respect to the Eligible Individual or Beneficiary.

**COORDINATION OF BENEFITS**

If you and your spouse or children are covered by this Plan and another plan providing medical or dental benefits (including, for example, a plan or policy of homeowner's insurance), they will be coordinated between the two plans. This provision is commonly called "Coordination of Benefits" or C.O.B. and limits total benefits payable under this Plan and other plans to one hundred (100%) of eligible charges.

When there are medical expenses for a family member covered by two (2) different group plans, you should file the claim with both plans. Make sure you provide all requested information to both plans. The respective claim departments will decide which plan is "primary" (pays benefits first) and which plan is "secondary" (pays eligible benefits not paid by the primary plan).
Definitions Applicable to these Coordination of Benefits Provisions

The terms "Other Plan" and "Another Plan" as used in these “Coordination of Benefits” provisions mean any plan providing benefits or services for or by reason of medical care or dental care or treatment or healing which benefits or services are provided by:

1. Group, blanket, franchise, or any other arrangement for coverage of individuals in a group whether on an insured or non-insured basis.

2. Group Blue Cross, Blue Shield, or other prepayment coverage provided on a group basis.

3. Group-Type Contracts other than individual insurance issued on a franchise basis. "Group-Type Contract" is a contract which is not available to the general public and can only be obtained and maintained through membership or affiliation with a particular organization or group.

4. Any coverage, group or group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

5. Any coverage for students which is sponsored by or provided through a school or other education institution which cover grammar, high school, and college students for accidents including athletic injuries either on a 24-hour basis or on a "to and from school" basis.

6. Any coverage under federal or state or other governmental programs, except Medicare, and any coverage required or provided by statute.

7. Coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit organization plan.

8. Medicare. For the purposes of this Article, the definition of Medicare will include both Part A and Part B of Medicare, whether or not the Eligible Individual is enrolled for both parts.

The terms "Other Plan" and "Another Plan" will not mean:

1. A state plan under Medicaid.

2. Benefits under a law or plan when, by law, its benefits are excess to those of any private insurance plan.

3. Individual or family coverage except those Plans described above.
4. Medicare with respect to (a) an actively employed Employee age sixty-five (65) and older or the spouse of an actively employed Employee age sixty-five (65) and older; (b) a disabled Eligible Individual who is making Self-Contributions to This Plan and who has exhausted benefits available to active participants as described in the “Summary of Benefits.”

5. Group Hospital Indemnity Plan of $100.00 per day or less.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not. Even so, the term "Plan" is deemed to include any Plan which is paid for entirely by an Employee, Retiree or Dependent only if such Plan contains a provision coordinating its benefits with This Plan.

The term "This Plan," as used in these “Coordination of Benefits” provisions, means that portion of the Carpenters and Joiners Welfare Fund which provides the medical and dental benefits subject to these “Coordination of Benefits” provisions.

The term "Allowable Expense," as used in these “Coordination of Benefits” provisions, means any necessary, Reasonable and Customary item of expense at least a portion of which is covered under at least one (1) of the Plans covering the individual with respect to whom a claim is made. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished will be deemed to be both an Allowable Expense and a benefit paid. The Trustees will not be required to determine the existence of any Plan or the amount of benefits payable under any Plan except This Plan, and the payment of benefits under This Plan will be payable under any and all other Plans only to the extent that the Trustees are furnished with information relative to such other Plans by the Employer or Employee or any insurance company or other organization or individual.

The term "Claim Determination Period," as used in these “Coordination of Benefits” provisions, means a period of one (1) year commencing on January 1.

Circumstances Under Which Coordination of Benefits will be Applied

Coordination of Benefits will be applied if the Eligible Individual has duplicate coverage with respect to the payment of part or all of a claim for benefits under any Other Plan.
Order of Benefit Payments

To administer this provision properly, and to determine whether the Plan Administrator will reduce its regular benefit, it is necessary to determine the order in which the various Plans will pay benefits. This will be determined as follows:

**Dependent/Non-Dependent.** The benefits of a Plan which covers the individual other than as a Dependent will be determined before the benefits of a Plan which covers the individual as a Dependent.

**Employee/Non-Employee.** The benefits of a Plan which covers the individual as an employee will be determined before the benefits of a Plan which covers such individual other than as an employee.

**Active/Inactive Employee.** The benefits of a Plan which covers an individual as an employee who is not retired or laid-off (or as that employee’s Dependent) will be determined before those of a Plan which covers that individual as a retired or laid-off employee (or as that employee’s Dependent). If the Other Plan does not contain this rule, this rule will be ignored.

**Dependent Children.** With respect to establishing the order of benefit determination on claims filed on behalf of a Dependent child, the following rules apply:

1. **Parents Not Legally Separated or Divorced.** With respect to claims filed on behalf of a Dependent child of parents who are not divorced or legally separated:
   a. **Birthday Rule.** The benefits of a Plan which covers the individual as a dependent of an individual whose date of birth, excluding year of birth, occurs earlier in a Calendar Year will be determined before the benefits of a Plan which covers such individual as a dependent of an individual whose date of birth, excluding year of birth, occurs later in a Calendar Year.
   b. **Same Calendar Day Date of Birth.** The benefits of a Plan which covers the individual as a dependent of an individual whose date of birth, excluding year of birth, occurs on the same calendar day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other individual for a shorter period of time.
   c. If the other Plan does not have the provisions of subparagraph 1(a) above regarding order of benefit determination for Dependent children which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the
other, the provisions of subparagraphs 1(a) above will not apply, and the rule set forth in the Plan which does not have the provisions of subparagraph 1(a) above will determine the order of benefits.

2. **Divorced or Legally Separated.** With respect to claims filed on behalf of a Dependent child of parents who are divorced or legally separated:

a. **Court Decree.** If there is a Qualified Medical Child Support Order ("QMCSO") which establishes financial responsibility for medical and health care expenses for a Dependent child, the benefits of a Plan which covers the child as a dependent of the parent with the financial responsibility will be determined before the benefits of a Plan which covers the child as a dependent of the parent without the financial responsibility.

b. **Parental Custody Without Remarriage.** In the absence of a QMCSO establishing financial responsibility for the medical and health care expenses of a Dependent child, and if the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

c. **Parental Custody With Remarriage.** In the absence of a QMCSO establishing financial responsibility for the medical and health care expenses of a Dependent child, and if the parent with custody of the child has remarried:

i. The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a Plan which covers the child as a dependent of the stepparent; and

ii. The benefits of a Plan which covers a child as a dependent of a stepparent will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

3. **If a Dependent child is covered under This Plan as an Employee, a claim submitted on behalf of such child will not be coordinated but will be paid only as a claim of an Employee.**

**Longer/Shorter Length of Coverage.** As to Plans for which the factors listed above do not establish an order of benefit determination, the benefits of the Plan which has covered the individual for the longer period of time will be determined.
before the benefits of a Plan which has covered such individual the shorter period of time.

"Other Plan" means any other plan of medical or dental expense coverage provided by group insurance or any other arrangement of coverage for individuals in a group, whether or not the plan is insured.

The Plan Administrator has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

**COORDINATION OF BENEFITS WITH OTHER TYPES OF INSURANCE**

This Plan is not in lieu of and does not affect the requirement for coverage under any plan of no-fault automobile insurance or other automotive insurance which provides medical coverage. That type of insurance is deemed to be primary for any claims arising out of the maintenance or use of an automobile. This Plan may require you to arbitrate any discontinuance or non-payment of no-fault benefits before a claim will be considered under This Plan.

Coverage under This Plan is deemed to be secondary coverage to any plan or policy of insurance which may pay medical expenses for a specific risk, including, but not limited to, for example, any automobile policy, homeowner's policy, or premises insurance policy.

The Plan may require that you show that you have made a reasonable effort to find out if there is an applicable other insurance policy. Benefits that might otherwise be payable under another insurance policy will not be paid by the Plan merely because you have not made a claim under the other insurance policy.

**COORDINATION OF BENEFITS WITH AUTOMOBILE INSURANCE**

This Plan will coordinate benefits with automobile insurance carriers as described in the following provisions:

1. Benefits payable under This Plan are not in lieu of those that would be payable under no-fault automobile insurance and do not affect any legal requirement that an individual maintain the minimum no-fault automobile insurance coverage within the jurisdiction in which that individual resides.

2. For any expenses arising from the maintenance or use of a motor vehicle, no-fault automobile insurance will calculate and pay its benefits first and This Plan will calculate and pay benefits second. The amount of benefits payable by This Plan will be coordinated so that the total amount paid will not exceed one hundred percent (100%) of the expenses incurred.
3. Benefits that otherwise might be payable under no-fault automobile insurance will not be payable by This Plan merely because no claim for no-fault benefits was filed. If you or an Eligible Dependent fail to maintain the legally required no-fault automobile insurance within the jurisdiction in which an individual resides, Plan benefits will not be payable for amounts which the legally required minimum amount of no-fault automobile insurance otherwise would have paid.

4. An individual injured in an automobile accident which is or should be covered by no-fault automobile insurance must arbitrate any notice of discontinuance of no-fault automobile insurance or no benefits for said injuries will be payable under This Plan.

COORDINATION OF BENEFITS WITH MEDICARE

If you have a claim for services otherwise covered by Medicare but which are instead provided under a private contract, This Plan will pay as if the services had been payable by Medicare.

For Retirees Eligible For Medicare

If you are a Retiree who is eligible for Medicare and you have, or could have, enrolled in Medicare Parts A and B, This Plan will coordinate its benefits with Medicare when you have a claim. This means that Medicare will pay first, and This Plan will pay second based on amounts not paid by Medicare. Eligible Individuals who are eligible to enroll for Medicare Part B, but who do not enroll when first eligible, will be subject to lesser benefits. Benefits will be paid as though the Eligible Individual had enrolled in Medicare Part B. Benefits will be coordinated using the active Employee Summary of Benefits.

For Individuals Under 65 (Employees and their Dependents only)

If an Eligible Family Member is Totally Disabled and is eligible for Medicare under the Medicare disability rules, Medicare will usually pay first on the individual's claims and This Plan will pay second. However, federal law sometimes may require This Plan to pay first as follows:

1. If an Eligible Family Member is entitled to Medicare for reasons other than being sixty-five (65) years of age or older, This Plan may pay before Medicare pays. Contact the Plan Administrator to see if this rule applies.

2. This Plan may pay before Medicare pays for individuals eligible for Medicare by reason of End Stage Renal Disease (ESRD) if that individual is eligible under the Plan through either Self-Contributions or Employer Contributions. In the event an Eligible Individual is required to enroll in
Part A and Part B of Medicare solely because of End Stage Renal Disease, benefits will be provided subject to the following terms:

a. Benefits payable under This Plan will be limited to the covered charges incurred during the initial thirty (30) consecutive months of treatment, beginning with either: (i) the first month in which renal dialysis treatment is initiated, or, (ii) in the case of a transplant, the first month in which the individual could become entitled to Medicare, providing a timely application was filed.

b. Benefits payable under This Plan beginning with the 31st month of treatment will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

This provision (for individuals under age sixty-five (65)) does not apply to Retirees or their Dependents.

EXCESS COVERAGE LIMITATION

Regardless of any other rule stating otherwise, all benefits payable under this Plan will be limited to being in excess of the benefits which are payable by any other plan or group insurance policy which is or purports to be an "excess policy" or an "excess plan" paying benefits only in excess of benefits provided by any other plan or policy.

If an entity or insurer of such other group "excess plan" or group "excess policy" agrees to pay benefits as if it were not an excess plan or policy, this Plan's benefits will be payable without regard to the provisions of the previous paragraph, subject to the Coordination of Benefit provisions.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for an individual to be determined before benefits are available under Medicare.

FILING FOR MEDICAL AND WEEKLY DISABILITY BENEFITS

When you have a medical or weekly disability claim, follow these steps:

Step 1: File a medical claim as soon as you or your Dependent incurs medical expenses. File your claim for disability benefits for Weekly Disability Benefits as soon as you must miss work due to the Total Disability.

Step 2: Obtain the necessary claim forms from the Plan Administrator.
Step 3: For Weekly Disability Benefit claims, have your Physician complete his or her sections of the claim form and return the form to the Plan Administrator.

Step 4: Make sure you have all the itemized bills relating to the claim such as prescription drug bills and Physician's bills. Each bill must show the name of the patient, the date and the charge for each service rendered, and the Sickness or Injury for which each item of expense was incurred. Bills for prescription drugs must include the patient's name, drug name, date, amount of charge, prescribing Physician's name and prescription receipt. Be sure that your full name, address, and Social Security number are on the bills. If the claim is for a Dependent, add the Dependent's name, Social Security Number and birth date.

Step 5: Send the itemized bills and claim forms to the Plan Administrator.

Before any claims can be paid for a Dependent spouse, a certified copy of your marriage certificate may be required to be on file at the office of the Plan Administrator.

CLAIM FILING AND PROCESSING PROCEDURES

Deadlines for Filing Claims

Medical and Disability Claims - The deadline for filing a claim for medical or disability benefits is fifteen (15) months after the date you incurred the claim. However, if extraordinary circumstances exist, the Plan will consider paying claims that occur after this deadline.

Prescription Drug Claims - All bills for prescription drugs must be filed no later than fifteen (15) months following the month in which the charge was incurred. Failure to do so will result in non-payment by the Plan.

Incomplete Claims

If you send a claim to the Plan Administrator and it cannot be processed because information is missing, you will receive a notice stating why the claim cannot be completed and what additional information is needed. It is your responsibility to send this information to the Plan Administrator. Approval or denial of a claim will be made within time frames listed below.

Pre-Service Claims

If the Plan states that a procedure requires preauthorization before it will be treated as a Covered Expense, you must submit the claim or the suggested course of treatment to the Plan well in advance of the service or treatment being performed. When you submit a claim for which preauthorization is required, the Plan will notify you if the claim is
authorized within fifteen (15) days of the Plan receiving the claim from you. If the Plan needs additional time in which to determine whether the claim is a Covered Expense, it can extend its determination for up to an additional fifteen (15) days as long as the Plan notifies you of its need for an extension within fifteen (15) days of the Plan receiving the claim. If the Plan’s need for the extension is due to your failure to provide the Plan with all the information it needs to process the claim, you will have forty-five (45) days after the Plan asks for additional information in order to provide the additional information to the Plan. If you failed to follow the Plan’s procedures for filing the claim, the Plan will notify you of this failure within five (5) days of it receiving the claim.

“Pre-Service Claims” are those claims for which your receipt of a benefit from the Plan is conditioned, in whole or in part, on approval from the Plan prior to you receiving the medical care.

The Plan will waive its preauthorization requirements if you have emergency services performed that would otherwise be covered under the Plan (this is also known as “urgent care”). You or the Provider, however, must notify the Plan as soon as reasonably possible after the services are performed. You will not be penalized for failing to obtain a preauthorization in an emergency situation, but the Plan will only pay the Usual and Customary Charge for services that are determined to be Medically Necessary.

An emergency (or urgent care) claim is a claim which (a) involves a procedure that requires preauthorization under the Plan either in a pre-service situation or for an extension of care in a concurrent care situation and (b) if applying the pre-authorization time frames for determining the claim, could seriously jeopardize the life or health of the Eligible Individual, seriously jeopardize the ability of the Eligible Individual to regain maximum function, or would subject the Eligible Individual to severe pain without the treatment that is the subject of the claim.

All Other Claims

If the Plan denies coverage for a claim, it will do so within thirty (30) days of the Plan’s receipt of the claim from you or your provider. In certain situations, the Plan may extend this by an additional fifteen (15) days; if it does, it will notify you of the extension within the original thirty (30) days and will tell you the reasons for the extension and when the Plan expects to make a decision on your claim. If the extension is needed because you failed to submit the necessary information to the Plan, the Plan will tell you of the information it needs and will give you forty-five (45) days to provide the needed information to the Plan.
Claim Denials
If your claim is denied, the Plan will notify you within the time frames stated above. The Plan will also:

1. Tell you the specific reasons your claim was denied;
2. Refer to the specific Plan provision(s) on which the determination was based;
3. Describe any additional material or information for you to complete the claim and an explanation of why the material or information is necessary;
4. Describe the Plan’s review procedures and the time limits for these procedures (which are also stated below), plus a statement concerning your rights under federal law if your claim is denied;
5. If an internal rule was relied upon by the Plan in making the decision, either give you a description of the rule or a notice that you can request a copy of the rule from the Plan; and
6. If the claim decision was based on a Medical Necessity or Experimental or Investigative treatment exclusion, either give you an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided to you upon your request.

Claim Appeal Procedure
If all or part of your claim is denied after the Plan has received all necessary claim information, you have the right to appeal the decision and request a review of the claim. The procedures for appealing a claim decision are:

1. Compose a claim appeal which explains why you believe your claim should be reviewed.
2. Attach any additional information you think will help a favorable decision to be made on your claim.
3. Return your completed appeal, along with any additional information you are submitting, to the Plan Administrator:

   Wilson-McShane Corporation  
   3001 Metro Drive, Suite 500  
   Bloomington, MN 55425

Your claim appeal must be filed in writing at the Plan Administrator’s office within one hundred eighty (180) days of the date the claim denial was mailed to you.
When appealing a claim, you have certain rights under federal law. These include:

1. You will have the opportunity to submit written comments, documents, records and other information relating to the claim.

2. You will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

3. The review by the Plan will take into account all comments, documents, records, and other information submitted by you related to your claim, whether or not the information was submitted or considered in the initial benefit determination.

Neither you nor any representative you appoint, however, has the right to make a personal appearance before the Board of Trustees.

Applicable Time Frames for Deciding Claim Appeals

Pre-Service Claims - If your appeal is for a denial of a claim requiring preauthorization, the Plan will notify you of its decision on appeal within thirty (30) days of the Plan's receipt of your appeal.

All Other Claims - For all other claims, the Board of Trustees will review your appeal at its next regularly scheduled meeting; however, if your appeal was received by the Plan within thirty (30) days of the Board of Trustees meeting, then your appeal will be reviewed at the Board's second regularly scheduled meeting following the Plan's receipt of your claim appeal. If special circumstances require, such as the need to hold a hearing, the review of your appeal may be delayed until the Board's third meeting following your request for an appeal. If this extension is required, the Plan will notify you of the extension and of the special circumstances requiring the extension.

After a decision is made concerning your appeal, you will be notified of the decision by the Plan within five (5) business days of the decision being made.

CIRCUMSTANCES RESULTING IN DENIAL OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny payment of a claim. The reason for denial may include one (1) or more of the following:

- The individual on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred.

- You did not file the claim within the Plan's time limits.
The expenses are not Covered Under The Plan or the expenses for which you filed the claim were not actually incurred.

The individual for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time (for example, a calendar-year maximum benefit, a lifetime maximum benefit, etc.).

No payment or a reduced payment was made because some or all of the expenses for which the claim was filed were applied against a deductible.

A third party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying the incurred medical expense and you or your Dependent, whether or not a minor, did not comply with the Subrogation provisions of this Plan.

Another plan was primarily responsible for paying benefits for the expenses (refer to "Coordination of Benefits" section in this document).

The Trustees amended the Plan eligibility rules or reduced Plan benefits.

The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that individual's behalf.

Your Employer terminated Contributions to the Plan, either because your Employer did not enter into a successor Collective Bargaining Agreement requiring Contributions to the Plan, or because the Participation Agreement providing for Contributions to the Plan was terminated.

You or your Dependents failed to make any required Self-Contribution.

The Plan was terminated.

You or your Eligible Family Member do not meet the regular eligibility requirements of the Plan.

The above list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types of circumstances that might cause the denial of benefits for your claim. If you have any questions about a denied claim, contact the Plan Administrator's office.
TERMINATION OF COVERAGE

EMPLOYEES

For Employees who are employed by a Contributing Employer in a job classification for which the Union is the collective bargaining agent, coverage will terminate:

1. Upon termination of the Plan.
2. Upon termination of Contributions on behalf of the Employee.
3. Upon the date on which the Employee fails to meet the Plan’s eligibility requirements.
4. When the Employee elects not to make any required Self-Contributions for COBRA Continuation Coverage at the beginning of each month:

   EXCEPTION: A Totally Disabled Employee’s coverage may be continued for a maximum of twenty-six (26) weeks during any period of disability. See "Maintenance of Eligibility for Employees Receiving Disability Benefits."

5. The date on which the employee is no longer eligible for benefits under the Continuation Coverage provisions of COBRA.
6. Upon Rescission of Coverage. (See “Rescission of Coverage” section)

For all other Employees:

1. Upon termination of the Plan.
2. Upon termination of Contributions on behalf of the Employee.
3. Upon the date on which the Employee fails to meet the eligibility requirements.
4. Upon the date that the Retiree discontinues or fails to make any required Self-Contributions.
5. At the end of the calendar month in which the Employer of the Employee ceases to participate in this Plan.
6. When the Participation Agreement providing for Contributions to the Plan was terminated.
The Carpenters and Joiners Welfare Fund

Termination of Coverage

7. The date on which the Employee is no longer eligible for benefits under the Continuation Coverage provisions of COBRA.

8. Upon Rescission of Coverage. (See “Rescission of Coverage” section).

DEPENDENTS

A Dependent's coverage will terminate at the earliest to occur of the following:

1. The date the Trustees terminate Dependent Benefits under the Plan.

2. The date the Employee ceases to be eligible for coverage under the Plan unless Self-Contributions for COBRA Continuation Coverage are made by or on behalf of the Dependent.

3. The date on which the Dependent becomes eligible for coverage as an Employee.

4. The date the Dependent ceases to meet this Plan’s definition of a Dependent, unless the Dependent is entitled to enroll and does enroll for continued coverage.

5. The date on which the Dependent is no longer eligible for benefits under the Continuation Coverage provisions of COBRA.

6. The date the Dependent becomes eligible for enrollment in a health plan established or maintained by the government of the United States or any state, including TRICARE.

7. Coverage is rescinded under the section entitled “Rescission of Coverage”.

RESCISSION OF COVERAGE

An Eligible Individual and individuals seeking coverage on behalf of an Eligible Individual may not engage in any fraudulent act, practice, or omission in connection with coverage under the Plan or make an intentional misrepresentation of material fact in connection with coverage under the Plan. If an Eligible Individual or a individual seeking coverage on behalf of an Eligible Individual engages in such act, practice, omission, or misrepresentation, the Eligible Individual’s coverage (including the coverage of any Eligible Dependent in the case of an Eligible Employee or Eligible Retiree and the coverage of the Eligible Employee or Eligible Retiree in the case of an Eligible Dependent) may be retroactively terminated or cancelled.
Retroactive termination or cancellation includes, but is not necessarily limited to, the following:

1. Any loss, expense, or charge incurred as a result of such act, practice, omission, or misrepresentation will not be covered;

2. The Eligible Individual (including any Eligible Dependent in the case of an Eligible Employee or Eligible Retiree and the Eligible Employee or Eligible Retiree in the case of an Eligible Dependent) will be required to reimburse the Plan for any claim erroneously paid by the Plan because of such act, practice, omission, or misrepresentation; and

3. The Trustees of the Plan may treat the Eligible Individual’s coverage (including the coverage of any Eligible Dependent in the case of an Eligible Employee or Eligible Retiree and the coverage of the Eligible Employee or Eligible Retiree in the case of an Eligible Dependent) as void from the time the act, practice, omission, or misrepresentation occurred.

The following are examples of fraudulent acts, practices, or omissions or intentional misrepresentations of material fact that may result in the retroactive termination or cancellation of an Eligible Individual’s coverage. Intentionally or fraudulently failing to:

1. Timely update his or her enrollment status;

2. Report to this Plan:
   a. His or her divorce;
   b. His or her legal separation;
   c. The death of a Dependent;
   d. His or her loss of custody of a Dependent child; or
   e. A Dependent child’s eligibility to enroll in an employer-sponsored health plan other than the group health plan of a parent;

3. Satisfy his or her Notification Responsibilities under this Plan; or

4. Honor the Plan’s right of subrogation and reimbursement or otherwise failing to cooperate with the Plan, as set out in the section entitled “GENERAL PLAN PROVISIONS”.

This is not a complete list of acts, practices, and omissions that are considered fraudulent or a complete list of intentional misrepresentations of fact considered
material. The requirements of this subsection do not limit the Plan’s ability to prospectively terminate your coverage.

**NOTIFICATION OBLIGATION**

Eligible Individuals must notify the Plan Administrator of any event or change in circumstance that affects:

1. Any Eligible Individual’s eligibility for coverage under the Plan; or

2. Any Eligible Individual’s eligibility for payment of any specific claim for benefits.

Notification must be provided to the Plan Administrator in writing within twenty (20) days of any such event or change in circumstances.

**CERTIFICATE OF CREDITABLE COVERAGE**

Effective June 1, 1997, upon termination of coverage of an Eligible Individual, the Plan will provide him or her with a Certificate of Creditable Coverage (by first class mail), which will state the length of time that the Eligible Individual was Covered Under The Plan, excluding periods of time before a significant break in coverage (a "significant break in coverage" is a continuous sixty-three (63) day period without group health care coverage).

You should retain this certificate in your personal files and submit it to any future employer who sponsors a group health care plan. The certificate may entitle you to a reduction in the waiting period for coverage of pre-existing condition under a new employer’s group health care plan if that plan includes a waiting period for the coverage of such conditions.
GENERAL PLAN PROVISIONS

BENEFICIARIES

You may designate or change your Beneficiary by filing a written request to the Plan Administrator. Ask the Plan Administrator for the necessary forms. The designation or change will be effective as of the date you execute the request, but the Plan will be completely discharged of its obligations to the extent of any payment made before receiving your request at the Plan Administrator.

PHYSICAL EXAMINATIONS

The Trustees have the right to have a Physician examine an individual for whom benefits are being claimed and to ask for an autopsy in the case of death. They also have the right to examine any and all hospital or medical records relating to a claim.

FREE CHOICE OF DOCTOR

You are free to choose any Physician you wish who meets the Plan’s definition of a legally qualified Physician. However, significant savings will be obtained by both you and the Plan by using In-Network Physicians.

GENETIC INFORMATION NONDISCRIMINATION ACT

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

GOVERNING LAW

All questions pertaining to the validity or interpretation of the Trust Agreement or the Plan or any question concerning the acts and transaction of the Trustees or any other matter that affects the Plan will be determined under federal law, where applicable federal law exists. If there is no applicable federal law, then the laws of the State of Minnesota will apply.

SUBROGATION

Introduction

The Plan has a first priority subrogation and reimbursement right if it provides benefits resulting from or related to an injury, occurrence or condition for which the Employee or Beneficiary has a right of redress against any third-party.

What does first priority right of subrogation and reimbursement mean? It means that if the Plan pays benefits which are, in any way, compensated by a third-party, such as an insurance company, the Employee or Beneficiary agrees that when a recovery is made from that third-party, the Plan is fully reimbursed out of that recovery for the benefits the
Plan previously paid. If the Employee or Beneficiary does not agree to the Plan’s subrogation and reimbursement rules, benefits will not be paid.

For example, the subrogation and reimbursement right may apply if an Employee or Beneficiary is injured at work, in an automobile accident, at a home or business, in an assault or in any other way for which a third-party has or may have responsibility. If a recovery is obtained from a third-party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The Employee or Beneficiary receives payment only after the Plan is fully reimbursed.

The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each Employee or Beneficiary in recognition of the fact that the value of benefits provided under the Plan will be maintained and enhanced by enforcement of these rights.

Subrogation and Reimbursement – Rules for the Plan

The following rules apply to the Plan’s right of subrogation and reimbursement:

1. **Subrogation and Reimbursement Rights in Return for Benefits**: In return for the receipt of benefits from the Plan, the Employee or Beneficiary agrees that the Plan has the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the Employee or Beneficiary or other individual deemed necessary by the Trustees, such as the attorney for the Employee or Beneficiary, will sign a form acknowledging the Plan’s subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the Employee or Beneficiary or other individual deemed necessary by the Trustees refuses to sign the acknowledgment. The Plan’s subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right are not impacted if the Employee or Beneficiary or other individual deemed necessary by the Trustees refuses to sign the acknowledgment.

2. **Constructive Trust or Equitable Lien**: The Plan’s subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Employee or Beneficiary from a third-party, whether by settlement, judgment or otherwise. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the Employee or Beneficiary fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan’s subrogation and reimbursement rights, the Plan reserves the right to, among other things, pursue all available equitable
action and offset any future benefits payable to the Employee, Dependent or Beneficiary under the Plan.

3. **Plan Paid First:** Amounts recovered or recoverable by or on the Employee or Beneficiary’s behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Employee or Beneficiary. The Plan’s subrogation and reimbursement right comes first even if the Employee or Beneficiary is not paid for all of their claims for damages. If the Plan’s subrogation and reimbursement rights are not fully satisfied directly by a third-party, the Plan’s right to reimbursement may be enforced to the full extent of any recovery that the Employee or Beneficiary may have received or may be entitled to receive from the third-party.

4. **Right to Take Action:** The Plan’s right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any other Plan participant can bring an action (including in the Employee’s or Beneficiary’s name) for specific performance, injunction or any other equitable action necessary to protect its rights in the cause of action, right of recovery or recovery by an Employee or Beneficiary. The Plan will commence any action it deems appropriate against an Employee or Beneficiary, an attorney or any third-party to protect its subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of Eligible Dependents covered by the Plan regardless of whether such Dependent is legally obligated for expenses of treatment.

5. **Applies to All Rights of Recovery or Causes of Action:** The Plan’s subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the Employee or Beneficiary has or may have against any third-party.

6. **No Assignment:** The Employee or Beneficiary cannot assign any rights or causes of action they may have against a third-party to recover medical expenses without the express written consent of the Plan.

7. **Full Cooperation:** The Employee or Beneficiary will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan’s subrogation and reimbursement rights. Benefits will be denied if the Employee or Beneficiary does not cooperate with the Plan.

8. **Notification to the Plan:** The Employee or Beneficiary must promptly advise the Plan Administrator, in writing, of any claim being made against any individual or entity to pay the Employee or Beneficiary for their injuries, sickness, or death. Further, the Employee or Beneficiary must
periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims.

9. **Third-Party**: “Third-party” includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers’ compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for an Employee’s or Beneficiary’s losses, damages, injuries or claims relating in any way to the injury, occurrence, conditions or circumstances leading to the Plan’s payment of benefits. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the Employee or Beneficiary.

10. **Apportionment, Comparative Fault, Contributory Negligence, Make-Whole and Common-Fund Doctrines Do Not Apply**: The Plan’s subrogation and reimbursement rights include all portions of the Employee or Beneficiary’s claims regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan’s subrogation and reimbursement rights are not affected, reduced or eliminated by comparative fault, contributory negligence, the make-whole and common-fund doctrines or any other equitable defenses.

11. **Attorney’s Fees**: The Plan will not be responsible for any attorney’s fees or costs incurred by the Employee or Beneficiary in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorney’s fees or costs.

12. **Course and Scope of Employment**: If the Plan has paid benefits for any injury which arises out of and in the course and scope of employment, the Plan’s right of subrogation and reimbursement will apply to all awards or settlements received by the Employee or Beneficiary regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney’s fees are awarded to the Employee or Beneficiary’s attorney from the Plan’s recovery, the Employee or Beneficiary will reimburse the Plan for the attorney’s fees.

**PLAN DISCONTINUANCE OR TERMINATION**

This Plan may be discontinued or terminated under certain circumstances, for example, if future Collective Bargaining Agreements and Participation Agreements do not require Employer Contributions to the Plan. In that event, benefits for Covered Expenses incurred before the termination date will be paid to Eligible Individuals as long as the
Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. Benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement, or the assets may be turned over to another employee benefit trust fund providing similar benefits. However, any use of such assets will be made only for the benefit of Eligible Individuals who were Covered Under The Plan at the time of the Plan termination.

RELEASE OF INFORMATION

You must provide the Plan Administrator with any required verbal or written authorization for the release of necessary information relating to any claim you have filed.

SEVERABILITY CLAUSE

If any provision or amendment to the Trust Agreement or the Plan should be determined or judged to be unlawful, such an illegality will apply only to the provision in question. It will not apply to any other provision of the Trust Agreement or the Plan unless such illegality would make it impractical or impossible for the Trust Agreement or the Plan to function.

TRUSTEE INTERPRETATION, AUTHORITY, AND RIGHTS

The Trustees have the authority to determine eligibility for benefits and construe the terms of the Plan, all Plan documents, rules, and procedures. Their interpretation will be final and binding on all individuals dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the Trustees that the decision will be upheld unless it is determined to be arbitrary or capricious.

The Trustees have the authority to change the eligibility rules and other provisions of the Plan; to amend, increase, decrease or eliminate benefits; and to terminate the Plan, in whole or in part. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them.

The right to change or eliminate any and all aspects of benefits provided for Retired Employees is a right specifically reserved to the Trustees, since the Retiree coverage is not an "accrued" benefit. The Trustees may reduce Retiree Benefits, increase Self-Contributions for Retiree Benefits, or completely terminate Retiree Benefits at any time. Such a change will be effective even though an Employee has already become a Retiree. The Trustees may adopt such rules as they feel are necessary, desirable, or
appropriate in the exercise of their fiduciary duty, and they may change these rules and procedures at any time.

**WORKERS' COMPENSATION**

This Plan is not in place of and does not affect any requirement for coverage under any workers’ compensation law, occupational diseases law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you did not file a claim for benefits under the rules of these laws.

**COVERAGE UNDER ANOTHER HEALTH CARE PLAN**

You must advise the Plan Administrator if you have coverage under any other health care plan. If this Plan pays primary benefits but later discovers that another plan should be responsible for paying primary benefits (and this Plan should be secondary), this Plan has the right to recover those benefits from you.
INFORMATION ABOUT THE PLAN

NAME OF PLAN/FUND
Carpenters and Joiners Welfare Fund.

TYPE OF PLAN
The Plan is a group health plan. The Plan provides medical, vision, dental, life, accidental death and dismemberment and disability benefits.

PLAN SPONSORSHIP AND ADMINISTRATION
Your Plan is sponsored and administered by a joint labor-management Board of Trustees. The Board is divided equally between Trustees appointed by the Union and by Trustees appointed by Contributing Employers.

The names and addresses of the Trustees are shown in the front of this document. The address and telephone number of the third-party Plan Administrator the Trustees have hired to help administer the Plan is:

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
(952) 854-0795 or (800) 535-6373

SERVICE OF LEGAL PROCESS
The name and address of the agent who the Trustees have appointed for service of legal process is:

Mr. Matthew Winkel
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Service of legal process may be made upon a Plan Trustee or the Plan Administrator.

SOURCE OF CONTRIBUTIONS/PLAN PARTICIPATION
The Plan receives Contributions from Employers who have entered into Collective Bargaining Agreements with Local Unions affiliated with the Union and are required to make Contributions to the Plan. Those Contributions are calculated according to a formula in the relevant Collective Bargaining Agreement which specifies a particular dollar amount to be contributed for each hour in covered employment. The Plan also receives Contributions from Employers who have Participation Agreements with the
The Carpenters and Joiners Welfare Fund Information About the Plan

Trustees to provide coverage for their Employees who are not bargaining unit members. In those cases, the Trustees will determine an Employer’s rate of Contribution when approving and executing the Participation Agreement. Contributions are made monthly to the Plan and enable Employees working under Participation Agreements to participate in the Plan.

Employees are entitled to participate in this Plan if they work under one of the Collective Bargaining Agreements or Participation Agreements and if their Employers make the required Contributions to the Plan on their behalf.

The Plan also receives Contributions from Employees, Retirees, and Dependents for the purpose of continuing coverage under the Plan. In those situations, the Trustees determine the rate of contribution according to applicable law.

ACCUMULATION OF ASSETS/PAYMENT OF BENEFITS

Employer Contributions and Employee, Retiree, and Dependent Self-Contributions are received and held in the Trust Fund by the Trustees pending the payment of benefits, insurance premiums, and administrative expenses.

All benefits paid by the Plan are self-insured. In other words, the Plan does not rely on insurance contracts with health insurance companies to pay for your claims. Instead, benefits are paid directly from the Trust Fund to you or the provider of services. These self-insured benefits payable by the Plan are limited to the Plan’s assets available for such purposes.

PLAN YEAR

The Plan Year is January 1 through December 31.

TRUST’S EMPLOYER IDENTIFICATION NUMBER & PLAN NUMBER

The employer identification number (EIN) assigned to the Trust Fund by the Internal Revenue Service is 41-6024791. The Plan number assigned by the Plan Sponsor is 501.

UNION

The North Central States Regional Council of Carpenters (formerly Lakes and Plains Regional Council of Carpenters and Joiners) is the Union that is a party to the Trust Agreement establishing the Trust Fund. The Union’s address is 700 Olive Street, St. Paul, MN 55130.

ASSOCIATION

The Carpentry Contractors’ Association (1270 Northland Drive, Suite 150, Mendota Heights, MN 55120), and the Associated General Contractors of Minnesota (Capital
Office Building, 525 Park Street, Suite #110, St. Paul, MN 55103-2186) are the Associations that are parties to the Trust Agreement establishing the Fund.

LIST OF EMPLOYERS AND EMPLOYEE ORGANIZATIONS

The Plan is maintained under one (1) or more Collective Bargaining Agreements between the Union and the Association. A complete list of Employers and employee organizations sponsoring the Plan, and a copy of any Collective Bargaining Agreements requiring Contributions to the Plan, are available upon written request to the Plan Administrator. They are also available for examination by Eligible Employees and Beneficiaries at the office of the Plan Administrator.

Eligible Employees and Beneficiaries may also receive from the Plan Administrator, upon written request, information as to whether a particular Employer or employee organization is a sponsor of the Plan and, if the Employer or employee organization is a Plan sponsor, the sponsor’s address.

QUALIFIED MEDICAL CHILD SUPPORT PROCEDURES

The Plan’s procedures for determining whether a court order qualifies as a Qualified Domestic Child Support Order are available from the Plan Administrator, free of charge.

PREFERRED PROVIDER NETWORK DIRECTORY

A directory of providers in the Plan’s preferred provider network will be furnished to you automatically, free of charge, in a separate document when you become eligible under the Plan. You can also get a copy of the directory from the Plan Administrator, free of charge.
YOUR RIGHTS UNDER ERISA

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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 and 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 documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue health care coverage for yourself or your Dependents if there is a loss of coverage under the Plan as the result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Plan of Benefits and the documents governing the Plan in the rules governing your COBRA Continuation Coverage rights.

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 should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date for coverage.
PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit 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 individual, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a Plan document or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to 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 file suit in Federal Court. In addition, if you disagree with the Plan’s decision or lack of decision concerning a Qualified Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the individual you have sued to pay those costs and fees. If you lose, the court may order you to pay those costs and fees, for example, 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 Plan of Benefits or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
DEFINITIONS

SUMMARY

This document contains many words and phrases that describe the benefits you may receive. Many words and phrases have been given specific meanings, and are defined in this section. For example, “Dependent” is defined to include many people in addition to your spouse and natural children. Defined words are capitalized in this document.

You should always check the definition of defined words and phrases so that you understand how they are used in this document.

ALUMNI EMPLOYEE - An Employee who satisfies any of the following requirements:

A. An individual who performed services for one (1) or more Employer that is a party to a Collective Bargaining Agreement (Contributing Employer) with the Union both as a bargaining unit employee and as a non-bargaining unit employee during the Calendar Year, provided at least half of the Employee’s hours of employment during the year were performed as a bargaining unit employee.

B. An individual who was employed by a Contributing Employer as a bargaining unit employee under a Collective Bargaining Agreement between his or her Employer and the Union with respect to all of his or her hours of employment during a Calendar Year (including Employees who satisfy the provisions of paragraph (A), above). For the purposes of this paragraph, a Collective Bargaining Agreement is applicable for a Calendar Year if it provided for the Employee to benefit in the Plan and was effective for any portion of that year.

C. An individual who is employed by a Contributing Employer who satisfies the provisions of paragraph (B) with regard to all of his or her hours of employment prior to the period described in paragraph (B), provided that the individual is performing services for one (1) or more Contributing Employers that are parties to the Collective Bargaining Agreement with the Union.

AMBULATORY SURGICAL CENTER - A licensed institution or facility affiliated with a Hospital, with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period.
**BENEFICIARY** - An individual who is not and was not an Employee or former Employee or Retiree, but who is or may in the future, by reason of the individual's relationship to an Employee or Retiree, be eligible for benefits under the Plan.

**BENEFIT PLAN; PLAN; PLAN OF BENEFITS** - The self-funded program of health and welfare benefits provided by the Carpenters and Joiners Welfare Fund, established by, and as it may be amended from time to time, the Board of Trustees pursuant to the provisions of the Trust Agreement.

**BODY MASS INDEX (“BMI”)** – A number which is a measure of weight for height and which can be calculated by a Physician to determine weight status.

**CALENDAR YEAR** - The 12-month period starting on January 1 of any year and ending on December 31 of that year.

**COLLECTIVE BARGAINING AGREEMENT(S)** - The Collective Bargaining Agreements in force and effect between the Union and a Contributing Employer which requires the Employer to make Contributions to the Plan on behalf of its Employees for work performed within the jurisdiction of the Union, together with any modifications or amendments of such Collective Bargaining Agreements.

**CONTRIBUTIONS** -

A. Payments made to the Plan by Employers pursuant to a Collective Bargaining Agreement on behalf of their Employees or pursuant to a Participation Agreement on behalf of their Alumni Employees for hours worked by the Employees, and also Employee payments to the Plan as required by such agreements;

B. Self-Contributions; and

C. Reciprocity Contributions.

**CONVALESCENT FACILITY** - An institution (or distinct part thereof) which has proper accreditation and fully meets every one of the following tests:

A. It is licensed to provide, and is engaged in providing, on an inpatient basis, for individuals convalescing from Injury or Sickness, professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered graduate nurse; also physical restoration services to assist patients in reaching a degree of bodily functioning to permit self care in essential daily living activities.

B. It provides for patient services under the full-time supervision of a Physician or registered graduate nurse.
C. It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse.

D. It has an effective utilization review plan.

E. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, custodial or educational care, or care of mental disorders.

**COVERED EXPENSES; COVERED MEDICAL EXPENSES** - The Reasonable and Customary Charges incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for services and supplies required for treatment of the individual as a result of a non occupational accidental bodily Injury or Sickness and for which Plan benefits are payable, subject to the Maximum Benefits specified on the Summary of Benefits.

**COVERED UNDER THE PLAN** - An individual who is eligible to receive the Plan benefits which are applicable to his or her eligibility status as an Eligible Employee, Eligible Retiree or Eligible Dependent.

**CUSTODIAL CARE** - Care which is designed to help an individual in the activities of daily living including preparation of special diets, supervision over medication that can be self-administered, and assisting the individual in and out of bed, to walk, bathe, dress, eat, etc.

**DENTIST** - An individual who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

**DEPENDENT** -

A. An individual who is:

1. The spouse of an Eligible Employee or Eligible Retiree who is a legal resident of the same country in which the Eligible Employee resides. For purposes of determining Dependent status, the term ‘spouse’ means the individual to whom the Eligible Employee or Eligible Retiree is married if the marriage is legally recognized under the laws of the state in which the marriage occurred. A legal civil union is considered a legal marriage for this purpose. The Plan may require that an Eligible Employee or Eligible Retiree provide a certified copy of his or her marriage before any benefits are paid for a Dependent spouse.

2. An Eligible Employee’s or Eligible Retiree’s child who is less than twenty-six (26) years old and is not eligible to enroll in an employer-sponsored health plan, including TRICARE, other than the group health plan of a parent.
3. An Eligible Employee’s or Eligible Retiree’s child who is age nineteen (19) but less than twenty-five (25) years old and would (i) be a registered full-time student in an accredited secondary school, college, university, or vocational or technical school or institute; and (ii) be dependent on the Employee or Retiree for the major portion of his or her support; but for the fact that the child is on a leave of absence (i) from an accredited post-secondary educational institution, (ii) which is medically necessary, (iii) which commenced while the child was suffering from a serious illness or injury, and (iv) which caused the child to lose registered full-time student status. The child must have been registered or enrolled as a full-time student immediately prior to the medically necessary leave of absence.

Dependent coverage under this section may be extended only until the earlier of: (i) the first anniversary of the start of the medically necessary leave of absence; or (ii) the date on which the Plan’s coverage would otherwise terminate due to the child’s reaching age twenty-six (26) or due to any other reason. The Plan must be provided with certification by the child’s treating Physician that states: (1) the child is suffering from a serious illness or injury, and (2) the leave of absence (or other change in enrollment) is medically necessary.

A child covered under this section will be entitled to at least the same level of benefits under the Plan during the leave of absence as the child was entitled to immediately prior to taking the leave. Also, if any changes are made to the Plan during the child’s leave of absence that increase the level of benefits available to Dependent children under the Plan, the child will remain eligible for the increased level of benefits in the same manner as other Dependent children.

4. An Eligible Employee’s or Eligible Retiree’s unmarried child age twenty-six (26) or older who is handicapped due to mental retardation or physical handicap. The coverage of the handicapped child will be continued for as long as the Employee or Retiree is Covered Under The Plan, provided that all of the following requirements are met:

a. The child must meet the definition of a child (see subpart B, below).

b. The child must have become so handicapped and incapable while a Dependent.
c. The child must remain handicapped due to mental retardation or physical handicap.

d. The child must be incapable of self-sustaining employment and continue to be incapable of such employment.

e. The child must have been Covered Under The Plan prior to the attainment of age twenty-six (26).

f. The child must be dependent upon the Eligible Employee or Eligible Retiree for the major portion of the child's support and maintenance (except to the extent the child is supported by another parent, is receiving governmental aid or assistance, or is the beneficiary of another trust) and must be domiciled with the parent.

g. At the time the first claim is filed on behalf of the child, the Eligible Employee or Eligible Retiree must furnish proof that the child was so handicapped while a Dependent. If the required proof is not received by the Plan, the child will not be considered an Eligible Dependent beyond the date he or she attains age twenty-six (26), even though such child continues to be handicapped.

h. Such mental retardation or physical handicap will be considered to have been established only if proof of such incapacity is furnished at least thirty-one (31) days prior to the date coverage would otherwise terminate. The Plan Administrator or its designee may require, at reasonable intervals, subsequent proof of the child's disability and dependency. The Plan Administrator will have the right to have a Physician of its choice examine the child periodically as a condition of continuing such child's status as an eligible child.

i. The child must be eligible to be claimed as a Dependent on the Eligible Employee’s or Eligible Retiree’s federal income tax return.

5. A child of a Dependent child described in paragraph (2) or (4) above and who is less than age nineteen (19). The child and the Dependent child must both reside with and rely upon the Eligible Employee or Eligible Retiree for a major portion of their support and maintenance.
B. For purposes of the definition of a Dependent, the term "child" means:

1. Any biological child of an Eligible Employee or Eligible Retiree.

2. Any child legally adopted by or placed for adoption with an Eligible Employee or Eligible Retiree. Placement for adoption means the assumption and retention by an Eligible Employee or Eligible Retiree of a legal obligation for total or partial support of a child in anticipation of the legal adoption of such child by the Eligible Employee or Eligible Retiree. Placement for adoption will terminate upon the termination of such legal obligation.

3. Any stepchild of an Eligible Employee or Eligible Retiree, meaning any child of Eligible Employee’s or Eligible Retiree’s current spouse from whom the Eligible Employee or Eligible Retiree is not divorced or legally separated:
   a. Who was born to such spouse;
   b. Who was legally adopted by such spouse;
   c. Who has been placed for adoption with such spouse; or
   d. Who is a foster child placed with such spouse by an authorized placement agency or a court.

4. Any foster child placed with an Eligible Employee or Eligible Retiree by an authorized placement agency or a court.

C. If an Eligible Employee's or Eligible Retiree's child is eligible for benefits under this Plan as an Employee or as a Retiree, such child will not be considered a Dependent under this Plan.

D. If an Eligible Employee’s or Eligible Retiree’s spouse is a full time active member of the military service or armed forces of any country or nation, such spouse or child will not be considered a Dependent under this Plan.

**DEPENDENT BENEFITS** - The benefits provided under this Plan with respect to Eligible Dependents of Eligible Employees and Eligible Retirees.

**DEVELOPMENTAL DELAY THERAPY SERVICES** - Services provided to Dependent children with developmental delay in which the following requirements are met:

A. The child’s developmental delay must be the result of an acute disease condition or injury.
B. The child’s developmental delay must be a minimum of two (2) years or two (2) grade levels behind normal development.

C. The services must be:

1. Provided to a covered child who has not previously reached the level of development expected for the child’s age in one (1) or more of the following areas of major life activity:
   a. Intellectual;
   b. Receptive and expressive language;
   c. Learning;
   d. Mobility;
   e. Self-direction;
   f. Capacity for independent living;
   g. Economic self-sufficiency.

2. Prescribed by the child’s attending Physician;

3. Provided by a Physician or an appropriate licensed therapist upon a Physician’s order and under a Physician’s general supervision;

4. Directly and specifically related to an active written treatment regimen designed by the Physician and the licensed therapist;

5. Based on the assessment made by the Physician and the licensed therapist, the treatment must reasonably be expected to produce significant improvement in the patient’s condition in a reasonable (e.g., normally sixty (60) days) and generally predictable period of time.

EFFECTIVE DATE – This Summary Plan Description and Plan Document for Participants of the Carpenters and Joiners Welfare Fund as amended and restated effective January 1, 2012.

ELIGIBLE DEPENDENT - Any Dependent who is eligible to receive the Plan benefits provided for Dependents of Eligible Employees and Eligible Retirees.

ELIGIBLE EMPLOYEE - Any Employee who has met the eligibility requirements specified in the section of this document entitled “Eligibility” and who is therefore entitled to receive the Plan benefits provided for Employees.

ELIGIBLE FAMILY MEMBER - An Eligible Employee or an Eligible Retiree or any individual in the Employee’s or Retiree’s family or household who meets the definition of a Dependent.
ELIGIBLE INDIVIDUAL - An Eligible Employee, an Eligible Retiree or an Eligible Dependent.

ELIGIBLE RETIREE - Any Retiree who has met the eligibility requirements specified under the section entitled “Continued Eligibility While Retired” and who is therefore entitled to receive Retiree benefits.

EMPLOYEE(S) -

A. All those individuals who are represented in collective bargaining by the Union and who are employed by an Employer who has agreed to make Contributions to the Plan on their behalf;

B. All regular Employees of the Eligible Employers listed in paragraphs (C)-(G) below provided that:
   
   1. The Employee is not participating in a health care plan established as a result of collective bargaining; and
   
   2. Participation of such Employees is in accordance with all applicable regulatory law and will not impair the tax exempt status of the Plan. The Trustees reserve the right to refuse or terminate participation of any such Employees if, in the Trustees’ sole discretion, such action is necessary or appropriate to preserve the Plan’s integrity or tax exempt status.

C. Employees of the Union provided that the Union has made written application to the Trustees requesting participation in the Plan for coverage for such Employees who are not covered under a Collective Bargaining Agreement, and provided further, that such Employer will have in effect a valid Participation Agreement with the Trustees.

D. Employees of one (1) of the Associations provided that the Association has made written application to the Trustees requesting participation in the Plan for coverage for such Employees who are not covered under a Collective Bargaining Agreement, and provided further that such Employer will have in effect a valid Participation Agreement with the Trustees.

E. Employees of an Employer who has made written application to the Trustees requesting participation in the Plan for coverage for its Employees who are not covered under a Collective Bargaining Agreement, and provided further that such Employer will have in effect a valid Participation Agreement with the Trustees.

F. Employees of an Employer member of one (1) of the Associations who has made written application to the Trustees requesting participation in the
Plan for coverage for its Employees who are not covered under a Collective Bargaining Agreement, and provided further that such Employer will have in effect a valid Participation Agreement with the Trustees.

G. Other Employees represented in collective bargaining by a Local Union affiliated with the United Brotherhood of Carpenters and Joiners as the Trustees may from time to time allow to participate in the Plan.

EMPLOYER; CONTRIBUTING EMPLOYER -

A. Any individual, firm, association, sole proprietorship, partnership or corporation that on the Effective Date of this Plan has entered into a Collective Bargaining Agreement with the Union requiring that Contributions be made to the Plan on behalf of their Employees;

B. Employers who in the future enter into a Collective Bargaining Agreement with the Union requiring that Contributions be made to the Plan on behalf of Employees at the same rate of Contribution as other Employers currently contributing or required to contribute to the Plan;

C. An Association in its capacity as an Employer of Employees not covered by a Collective Bargaining Agreement provided such Association will have in effect a valid Participation Agreement with the Trustees;

D. The Union in its capacity as Employer of Employees not covered by a Collective Bargaining Agreement provided that the Union will have in effect a valid Participation Agreement with the Trustees;

E. Any other Employer of Employees not covered by a Collective Bargaining Agreement provided that the Employer will have in effect a valid Participation Agreement with the Trustees;

F. Employers who are members of one (1) of the Associations provided such Employer will have in effect a valid Participation Agreement with the Trustees.

G. Employers who enter into a Collective Bargaining Agreement with a Local Union affiliated with the United Brotherhood of Carpenters and Joiners, from whom the Trustees have agreed to accept Contributions to the Plan.

ESSENTIAL HEALTH BENEFITS - Any benefits covered by the Plan that constitute Essential Health Benefits as that term is defined under the Patient Protection and Affordable Care Act (“Affordable Care Act“) or related regulations, rules, or guidance. As defined under the Affordable Care Act, Essential Health Benefits means at a minimum, any medical services that are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder
services, including behavioral health treatment; prescription drugs; rehabilitative and
habilitative services and devices; laboratory services; preventive and wellness services
and chronic disease management; and pediatric services, including oral and vision care.

In no situation will Essential Health Benefits mean any medical services that are not
Essential Health Benefits under the Affordable Care Act (or any amended version of the
Affordable Care Act) or any medical services the payment for which is not a Covered
Expense under the Plan.

EXPERIMENTAL OR INVESTIGATIVE - For purposes of this Plan, the use of any
treatment (which includes use of any treatment, procedures, facility, drug, equipment,
device, or supply) is considered to be Experimental or Investigative if the use is not yet
generally recognized as accepted medical practice, or if the use requires federal or
other governmental agency approval and the approval has not been granted at the time
the service or supply is provided, or if the use is not supported by Reliable Evidence (as
defined below) which shows that, as applied to a particular condition, it:

A. Is generally recognized as a safe and effective treatment of the condition
   by those practicing the appropriate medical specialty;

B. Has a definite positive effect on health outcomes;

C. Over time leads to improvement in health outcomes under standard
   conditions of medical practice outside clinical investigatory settings (i.e.,
   the beneficial effects outweigh the harmful effects); and

“Reliable Evidence” includes only:

A. Published reports and articles in authoritative medical and scientific
   literature;

B. The written investigational or research protocols and/or written informed
   consent used by the treating facility or of another facility which is studying
   the same service, supply, or procedure; and

C. Compilations, conclusions, and other information which is available and
   may be drawn or inferred from (A) or (B), above.

Consideration may be given to whether:

A. The treatment cannot be lawfully marketed without approval of the U.S.
   Food and Drug Administration and approval for marketing has not been
   given at the time the treatment is furnished; or

B. Reliable Evidence shows that the treatment is the subject of ongoing
   Phase I, II or III clinical trials or under study to determine its maximum
tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

C. Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

D. The mortality rate of the treatment; the cure rate and the survival rate for patients using the treatment for the particular Injury, Sickness or condition as compared with rates for similarly situated patients using no treatment or using existing treatments which are generally accepted by the Food and Drug Administration; and the number of patients who have received the treatment for the same Injury, Sickness or condition.

The final determination of whether the use of a treatment is Experimental or Investigative will rest solely with the Trustees.

HOME HEALTH CARE AGENCY - An agency or organization which fully meets every one of the following requirements:

A. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.

B. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) registered graduate nurse (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a Physician or registered graduate nurse.

C. It maintains a complete medical record on each individual.

D. It has a full-time administrator.

HOME HEALTH CARE PLAN - A program for care and treatment of the individual established and approved in writing by the individual’s attending Physician. The attending Physician must certify that the proper treatment of the Sickness or Injury would require confinement as a resident inpatient in a Hospital or Convalescent Facility in the absence of the services and supplies provided as part of the Home Health Care Plan.

HOSPICE CARE - Care given to a terminally ill individual by or under arrangements with a Hospice Care Agency. The care must be a part of a Hospice Care Program.
HOSPICE CARE AGENCY - An agency or organization which meets all of the following requirements:

A. Has Hospice Care available twenty-four (24) hours a day.

B. Meets any licensing or certification standards set forth by the jurisdiction where it is located.

C. Provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family.

D. Provides or arranges for other services which will include services of a Physician, physical or occupational therapy, part-time home health aide services which mainly consist of caring for terminally ill individuals, and inpatient care in a facility when needed for pain control and acute and chronic symptom management.

E. Has personnel, which includes at least one (1) Physician, one (1) registered nurse (R.N.), one (1) licensed or certified social worker employed by the agency, and one (1) pastoral or other counselor.

F. Has established policies governing the provision of Hospice Care.

G. Assesses the patient’s medical and social needs.

H. Develops a Hospice Care Program to meet the patient’s medical and social needs.

I. Provides an ongoing quality assurance program. This includes reviews by Physicians other than those who own or direct the agency.

J. Permits all area medical personnel to utilize its services for their patients.

K. Utilizes volunteers trained in providing services for non-medical needs.

L. Has a full-time administrator.

HOSPICE CARE PROGRAM - A written plan of hospice care which meets all of the following requirements:

A. Is established by and reviewed from time to time by a Physician attending the individual and appropriate personnel of a Hospice Care Agency.

B. Is designed to provide relief or easing of pain and supportive care to terminally ill individuals and supportive care to their families.
C. Includes an assessment of the individual’s medical and social needs and provides a description of the care to be rendered to meet those needs.

HOSPICE FACILITY - A facility, or distinct part of one, which meets all of the following requirements:

A. Mainly provides inpatient hospice care to terminally ill individuals.

B. Charges its patients for expenses incurred.

C. Meets any licensing or certification standards set forth by the jurisdiction where it is located.

D. Keeps medical records on each patient.

E. Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.

F. It is run by a staff of Physicians. At least one such Physician must be on call at all times.

G. Provides 24-hours-a-day nursing services under the direction of a registered graduate nurse (R.N.).

H. Has a full-time administrator.

HOSPITAL - A lawfully operating institution which is engaged primarily in providing medical care and treatment to sick and injured individuals on an inpatient basis at the patients' expense and which meets all of the following requirements:

A. It is a Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations;

B. With respect to treatment of mental or nervous disorders, it is a community mental health center or mental health clinic established for the purpose of providing consultation, diagnosis and treatment in connection with a mental Sickness or functional nervous disorder and is approved or licensed by the commissioner of public welfare or other authorized state agency;

C. With respect to an Emotionally Handicapped Child, it is a licensed residential treatment facility established for the purpose of treating emotionally handicapped children and approved or licensed by the State of Minnesota. "Emotionally Handicapped Child" is a child under nineteen years of age who, in the judgment of a professional, social worker,
psychiatrist, or psychologist, is exhibiting those symptoms or behavior patterns that are determined to be of such a nature that the child needs the care and treatment provided at such facility;

D. With respect to the treatment of alcoholism, chemical dependency or drug addiction, it is confinement in a residential primary treatment program licensed by the state of Minnesota;

E. It is a Hospital, a psychiatric Hospital, or a tuberculosis Hospital, as those terms are defined in Medicare, which is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; and

F. It is an institution which meets all of the following requirements:

1. It provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick individuals under the supervision of a staff of Physicians licensed to practice medicine;

2. It provides on the premises 24-hour-a-day nursing services by or under the supervision of registered graduate nurses (R.N.);

3. It is operated continuously with organized facilities for operative surgery on the premises; and

4. It is not an institution which is primarily a clinic or, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing or convalescent home, an extended care facility, a place for Custodial Care, or similar establishment.

INHERITED METABOLIC DISORDERS - A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis; also referred to as inborn errors of metabolism; includes Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria, and Galactosemia; but includes neither lactose intolerance (without a diagnosis of Galactosemia) nor diabetes.

INJURY - Bodily Injury caused by an accident while Covered Under The Plan.

INTENSIVE CARE UNIT - A special area of a Hospital, exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:

A. Personal care by specialized registered professional nurses and other nursing care on a twenty-four (24) hour per day basis;
B. Special equipment and supplies which are immediately available on a stand-by basis; and

C. Care required but not rendered in the general surgical or medical nursing units of the Hospital. The term "Intensive Care Unit" will also include an area of the hospital designated and operated exclusively as a coronary care unit or as a cardiac care unit.

D. Not included is any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

MEDICAL FOODS - Special foods or formulas that are essential for the growth, health, and metabolic homeostasis of an individual who has an Inherited Metabolic Disorder and are administered under the direction of a Physician and include:

A. Modified low protein foods and formulas that are specially formulated to contain less than one gram of protein per unit of serving and are administered for the medical and nutritional management of a individual who has limited ability to properly metabolize food or nutrients; and

B. Metabolic formulas, which are solutions consumed or administered through the gastrointestinal tract and are processed or formulated to properly metabolize food or nutrients;

but do not include natural foods low in protein and/or galactose, spices, flavorings, or foods or formulas required by individuals who do not have an Inherited Metabolic Disorder.

MEDICALLY NECESSARY - Only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an Eligible Individual's Injury or Sickness and which:

A. Are consistent with the symptoms or diagnosis and treatment of the Eligible Individual's condition, disease, ailment, or Injury;

B. Are appropriate according to standards of good medical practice;

C. Are not solely for the convenience of the Eligible Individual, (including his or her family or care giver) Physician, or Hospital;

D. Are the most appropriate which can be safely provided to the Eligible Individual;

E. Are not deemed to be Experimental or Investigative; and
are not furnished in connection with medical or other research.

**MEDICARE** - The Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such program is currently constituted and as it may later be amended.

**MENTAL OR NERVOUS DISORDER** - A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

**MOTOR VEHICLE** - Any registered or unregistered, licensed or unlicenced, on-road or off-road automobiles, trucks, motorcycles, recreational vehicles, or motor homes.

**NURSE MIDWIFE** - A licensed registered nurse who is certified as a Nurse Midwife by the American College of Nurse-Midwives and is authorized to practice as a Nurse Midwife under state regulations.

**ORAL SURGERY** - Any procedure performed on the teeth, mouth or jaw which may be performed by a Doctor of Dental Surgery (D.D.S.) or Oral Surgeon.

**OUTPATIENT SURGERY** - Surgical procedures performed at a Hospital or an Ambulatory Surgical Center for which the patient does not stay overnight but has the surgical procedure done on the same day and released on the same day of admittance.

**PARTICIPATION AGREEMENT** - A written agreement between the Trustees and an Employer whereby the Trustees approve the participation by Employees of the Employer in the Plan and which shows the commitment of the Employer to be bound by the Trust Agreement as if an original party to it, and whereby the Employer agrees to make and the Trustees agree to accept Contributions to the Plan on behalf of the Employer's Employees who are not members of the bargaining group. The Trustees, in approving and executing any Participation Agreement, will by appropriate action determine the rate of Contribution to be paid to the Plan by the Employer on behalf of its Employees.

**PHYSICIAN** -

A. A legally qualified Physician or surgeon licensed to practice in his or her state who is a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Chiropractic (D.C.), a Doctor of Dentistry (D.D.S., D.M.D.) or a Doctor of Podiatry (D.P.M.) acting within the scope of their respective licenses.
B. A Nurse Midwife with respect to treatment, service, or care rendered by the Nurse Midwife within the lawful scope of practice of a duly certified Nurse Midwife.

PLAN YEAR – The Plan Year is January 1 through December 31.

QUALIFIED MEDICAL CHILD SUPPORT ORDER - Any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or a decision from a state administrative body that:

A. Provides for child support payments related to health benefits with respect to a child or requires health benefit coverage of such child by the Plan, and is ordered under state domestic relations law; or

B. Enforces a state law relating to medical child support payments with respect to the Plan; and

C. Creates or recognizes the right of a child as an alternate recipient who is recognized under the Order as having a right to be enrolled under the Plan to receive benefits derived from the child's relationship to a full-time Eligible Employee who participates in the Plan; and

D. Includes the name and last known address of the Eligible Individual from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided, and each plan, including this Plan, to which the order applies; and

E. Does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1980 of the Social Security Act; and

F. Has been determined to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan.

REASONABLE AND CUSTOMARY CHARGE; REASONABLE AND CUSTOMARY -

A. A charge that does not exceed the general level of charges being made by providers of similar training and experience when furnishing customary treatment for a similar Sickness, condition, or Injury. The locality where the charge is incurred will also be considered. "Locality" means a county or the greater area as is necessary to establish a representative cross section of providers regularly furnishing the type of treatment, services or supplies for which the charge was made.
B. With respect to medical expenses incurred by an Eligible Individual as a result of a non occupational accidental Injury or Sickness, the Plan's maximum allowable expense for a charge by a Physician or any other provider of medical services or supplies is the applicable percentage as specified under the Plan's "Summary of Benefits" provided that the Plan may review and compare the charge with the charges made by other Physicians and providers of medical services or supplies for similar services or supplies in the Locality concerned to individuals of similar age, sex, circumstances, and medical condition.

C. With respect to dental and orthodontia expenses, the Reasonable and Customary Charge is established by a contract between Delta Dental and its participating Dentists. Reasonable and Customary Charges for non-participating Dentists is also based upon that contract.

D. A Reasonable and Customary Charge will not exceed charges actually incurred.

**RETIREE; RETIRED EMPLOYEE** - An individual who was an Eligible Employee under this Plan on the day preceding the date of retirement and who is now retired either under the retirement provisions of a pension plan negotiated or sponsored by the Union or under the provision of the Social Security Program, provided that:

A. The Employer of the Employee is a party to the Collective Bargaining Agreement at the time the Eligible Employee retires.

B. The Eligible Employee is at least fifty-five (55) years of age and no longer actively at work in the trade.

C. The Eligible Employee makes the necessary Self-Contributions as discussed under the “Continued Eligibility While Retired” section of this document.

E. The Employee is either:

1. An Employee who established eligibility for coverage under this Plan while working in employment subject to a Collective Bargaining Agreement as defined in this document; or

2. The Employee established eligibility for participation in this Plan while an Employee of the Union or while an Employee of one of the Employers or while an Employee of any Plan or an agency created pursuant to collective bargaining between the Employer(s) and the Union; or
3. The Employee established eligibility for coverage in the Plan while an Employee of an Employer subject to a Collective Bargaining Agreement.

ROOM AND BOARD CHARGES - All charges made by a Hospital on its own behalf for room, board, general duty nursing and any other charges by whatever name called which are regularly made by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of Physicians, private duty nurses or charges for intensive nursing care.

SELF-CONTRIBUTIONS -
A. Payments made to the Plan on behalf of Employees of Employers signatory to a Collective Bargaining Agreement for the purpose of maintaining eligibility;
B. Payments made to the Plan by Retirees and surviving spouses of Retirees for the purpose of maintaining eligibility; and
C. Payments made to the Plan for Continuation Coverage Under COBRA by Employees, Retirees and Dependents for the purpose of maintaining their coverage under the Plan (see “Continuing Eligibility Through Self-Contributions (Continuation Coverage Under COBRA)").

SICKNESS - An illness or disease which occurs while Covered Under The Plan.

SUPPLEMENTAL RESERVE CREDITS - See subsection entitled “Supplemental Reserve Credits” on page 10.

TMJ - Conditions including but not limited to temporomandibular joint syndrome, craniomandibular disorders, and other conditions of the joint linking the jaw bone and the skull, along with the complex of muscles, nerves and other tissues related to that joint. For the purposes of the Plan, the term "TMJ" will include all of the above conditions.

TOTAL DISABILITY; TOTALLY DISABLED -
A. With respect to an Eligible Employee, the complete inability of the Eligible Employee, as a result of an accidental bodily Injury or Sickness, to engage in his or her occupation or employment for wage or profit. The disability must be verified periodically by an attending Physician's statement.
B. With respect to an Eligible Retiree or an Eligible Dependent, the complete inability, as a result of non occupational accidental bodily Injury or Sickness, of the Retiree or Dependent to engage in the substantial and material activities engaged in prior to the start of the disability.
C. With respect to a Dependent child, as a result of an accidental bodily injury or sickness, confinement in a house or hospital.

D. A disability will be declared a Permanent Total Disability if it continues for a period of at least six (6) months or to the date of death.

**TRUST AGREEMENT** - The Restated Agreement and Declaration of Trust establishing the Carpenters and Joiners Welfare Fund, as may be amended from time to time.

**TRUST FUND; FUND** - The Carpenters and Joiners Welfare Fund, the Trust Fund created pursuant to the Third Amended Agreement and Declaration of Trust and consisting generally of all the monies, property and other things of value held by the Trustees under the provisions of the Restated Agreement and Declaration of Trust and any future amendments thereto and which comprise corpus and additions, without distinction as to principle and income.

**TRUSTEE; TRUSTEES; BOARD OF TRUSTEES** - A Trustee or the Trustees designated pursuant to the Trust Agreement together with such Trustee's successor or such Trustees' successors. The term "Employer Trustees" will mean the Trustees appointed by the Employers. The term "Union Trustees" will mean the Trustees appointed by the Union.

**UNION** - The North Central States Regional Council of Carpenters (the "Council"), those Local Unions affiliated with the Council, and those Local Unions affiliated with the United Brotherhood of Carpenters and Joiners that collectively bargain for Contributions to be made to the Plan.
MEDICAL DATA PRIVACY

INTRODUCTION

Recently, the federal Department of Health and Human Services adopted regulations governing the Plan’s use and disclosure of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). While the Plan has always taken care to protect the privacy of your health information, the new regulations require the Plan to adopt more formal procedures and to tell you about these procedures in this Plan of Benefits. The information below discusses ways in which the Plan uses and discloses your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

1. The Plan’s uses and disclosures of Protected Health Information (“PHI”);
2. Your privacy rights with respect to your PHI;
3. The Plan’s duties with respect to your PHI;
4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
5. The individual or office to contact for further information about the Plan’s privacy practices.

THE PLAN’S USE AND DISCLOSURE PHI

The Plan will use PHI to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations (“Privacy Regulations”) adopted under HIPAA, including for purposes related to Health Care Treatment, Payment, and Health Care Operations.

The Plan will enter into agreements with other entities known as “Business Associates” to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate’s duties on behalf of the Plan. The Plan’s agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

USE OF PHI FOR TREATMENT PURPOSES

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes but is not limited to consultations and referrals between one (1) or more of your providers. As a health plan, the Plan is
generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

**USE OF PHI FOR PAYMENT AND HEALTHCARE OPERATIONS**

*Payment* includes the Plan’s activities to obtain premiums, Contributions, self-payment, and other payments to determine or fulfill the Plan’s responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determining eligibility or coverage under the Plan;
2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);
3. Subrogation;
4. Coordination of Benefits;
5. Establishing self-payments by individuals covered under the Plan;
6. Billing and collection activities;
7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered individuals’ inquiries about payments;
8. Obtaining payment under stop-loss or similar reinsurance;
9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;
10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective reviews;
12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the Plan.

*Health Care Operations* can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;

3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

6. Management and general administrative activities of the Plan, including but not limited to:
   a. Managing activities related to implementing and complying with the Privacy Regulations;
   b. Resolving claim appeals and other internal grievances;
   c. Merging or consolidating the Plan with another plan, including related due diligence; and
   d. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.
OTHER USES AND DISCLOSURES OF PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered individuals, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the individual or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

RELEASE OF PHI TO THE BOARD OF TRUSTEES

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the Plan documents, including this Plan of Benefits, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

1. Not use or further disclose PHI other than as permitted or required by the Plan of Benefits or as required by law.

2. Ensure that any agents (such as Union business agents or the Trustees’ staffs), including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual who is the subject of the PHI;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual who is the subject of the information;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

6. Make PHI available to an individual who is the subject of the information according to the Privacy Regulations’ requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

8. Make available the PHI required to provide an accounting of disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan’s compliance with the Privacy Regulations; and

10. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

TRUSTEE ACCESS TO PHI FOR PLAN ADMINISTRATION FUNCTIONS

As required under the Privacy Regulations, the Plan will give access to PHI only to the following individuals:

1. The Board of Trustees.

   The Plan will release PHI to the Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered individuals with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

2. The Trustees’ agents, such as Union business agents, and the Trustees’ staffs, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the above uses and disclosures of PHI.

NONCOMPLIANCE ISSUES

If the individuals described above do not comply with this Plan of Benefits, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

PLAN’S PRIVACY OFFICER AND CONTACT INDIVIDUAL

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Individual to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Individual if you have any complaints
concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan Administrator and ask to speak with the Plan’s Contact Individual.
HIPAA SECURITY

INTRODUCTION

Recently, the federal Department of Health and Human Services adopted regulations governing the Plan’s obligation to maintain the security of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). These regulations work in conjunction with the Medical Data Privacy Regulations (“Privacy Regulations”), which provisions are contained on pages 149-154 of this Plan of Benefits. While the Plan has always taken care to secure your health information, the new regulations require the Plan, along with the Plan Administrator, to take some additional steps, in addition to those required by the Privacy Regulations, to maintain the electronic, physical and technical security of your PHI. The information below outlines the additional steps the Plan has taken to secure your PHI in compliance with the HIPAA Security Regulations.

A. Policies to Protect Electronic PHI

The Plan has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI in electronic form (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) created, received, maintained or transmitted on behalf of the Plan. The Trustees will report to the Plan any security incident of which they become aware.

B. Business Associates

The Plan will enter into agreements with other entities known as “Business Associates” to perform functions as part of the administration of the Plan. The Plan’s agreements with its Business Associates will require that the electronic, physical and technical security of your electronic PHI be maintained.

C. Access to Electronic PHI for Plan Administrative Functions

As indicated in the amendment covering the Privacy Regulations, the Plan will give access to PHI to the Board of Trustees. Any such disclosures of your PHI in electronic form to the above noted personnel are supported by reasonable and appropriate security measures. If any of the above noted personnel fail to comply with these provisions, the Board of Trustees will provide a mechanism for resolving issues of noncompliance.
D. If You Have Any Questions

The Plan Administrator is largely responsible for maintaining the security of your PHI. The Plan Administrator has appointed a Security Officer for purposes of Security Regulations compliance. If you have questions regarding the security of your PHI in electronic form, you may contact the Security Officer through the Plan Administrator.
PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, (the “Affordable Care Act”) imposes a number of requirements on group health plans, such as this Plan. The federal Departments of Health and Human Services, Treasury, and Labor have jointly issued regulations implementing some provisions of the Affordable Care Act. While the Board of Trustees has taken care to ensure that the terms of the Plan comply with the requirements of the Affordable Care Act, a significant amount of ambiguity remains as to the requirements of the Affordable Care Act. The terms and provisions of the Plan will be construed, to the extent possible, to comply with the Affordable Care Act, or any amended version of the Affordable Care Act. If it is determined that any term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act, or any amended version of the Affordable Care Act, that term or provision will not be enforced to the extent that it does not comply with the Affordable Care Act. A determination that a term or provision of the Plan cannot reasonably be construed to comply with the Affordable Care Act will not affect any other term or provision of the Plan.
IN WITNESS WHEREOF, the Trustees have caused this Summary Plan Description and Plan Document, effective January 1, 2012, for the Carpenters and Joiners Welfare Fund to be executed on the 30th day of November, 2011.

UNION: ___________________________  EMPLOYER: ___________________________

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