Late Season 2022

BENEFITS TOOLBOX

A Publication of the New York City District Council of Carpenters Benefit Funds

United Healthcare

UnitedHealthcare "UHC" to Offer Lifeline® Personal Emergency Response System "PERS" *at No Cost to Covered Medicare-Eligible Retirees*

We have great news for Medicare-Eligible NYCDCC Welfare Fund participants who are covered under UnitedHealthcare ("UHC")! Effective January 1, 2023, UHC will offer Lifeline Personal Emergency Response System ("PERS") at no cost to covered participants who wish to utilize the service. PERS is a system that allows you to ask for help whenever you need it, day or night, 365 days per year. To summon assistance, all you need to do is press the help button, which is located on the hardware provided (it can be worn as a pendant or wristband). Once help is requested, a Trained Care Specialist will assist you and make sure you are provided with whatever services you need.

Some features of PERS include:

- Optional AutoAlert fall detection technology automatically provides access to help if it detects a fall – even if the wearer is disoriented, immobilized, or unconscious, and cannot press the help button.
- Cellular or landline compatible, Lifeline works anywhere in the U.S., where current telephone service is provided.
- Lightweight, waterproof help button can be worn on the wrist or as a pendant.

Participants, family members, caregivers, and healthcare professionals may enroll a participant by:

- Calling: 1 (855) 595-8485, TTY 771
  Monday through Friday:
  8am to 8:30pm ET
  Saturday:
  10am to 4pm ET
- Emailing: LifelineCares@Philips.com
- Faxing: 1 (800) 548-7695
- Online: lifeline.philips.com/uhcgroup

Please be sure to have the following information available:

- Address
- Telephone number to schedule delivery
- Date of birth
- Preferred language

For more information, visit our website at **www.nyccbf.org**.

REMINDER: A Failure to Timely Report a Divorce to the NYCDCC Welfare Fund May Have a Severe and Crushing Impact on Your Finances, Health Coverage, and Family's Health Coverage

Failing to report a divorce while you have a spouse listed as a dependent under the NYCDCC Welfare Fund (the "Fund") may result in grave financial repercussions and the loss of your health coverage. This is especially true if your former spouse receives costly medical treatments after he/she is no longer eligible for coverage. Please read this explanation of the Fund's rules and an example of how failing to follow these rules may impact you financially.

Divorce Rules for Health Benefits- If you get a divorce, your former spouse will remain covered under the Fund until the last day of the month in which the judge signs your divorce judgment. It is extremely important that you provide a copy of your divorce judgment to the Fund as soon as possible so that your former spouse's coverage is terminated at the end of the month in which **the judge signed the divorce judgment**. You and your former spouse will be liable for any benefits paid on behalf of your former spouse after the last day of the month in which **the judge signed the divorce judgment**. In addition, in order for your former spouse to be eligible for COBRA coverage, you or your former spouse must provide notice of your divorce within **60** days of the date of divorce. If the Fund does not receive notice of the divorce within 60 days of the divorce, your former spouse will lose his/her COBRA rights. Additionally, a delay in timely notification will make you (along with your former spouse) personally liable for any health claims paid by the Fund on behalf of your former spouse after he/she ceased to be eligible. Even if you think your former spouse has provided notice, we urge you to provide notice to eliminate any doubts since you will both be responsible for any claims paid in error. If you are a Retiree, your monthly premium will be reduced to reflect the removal of your former spouse from your Welfare Fund Retiree Coverage.

As you can see from this example, failing to timely notify the Fund of a divorce and not having your ex-spouse properly removed as a dependent can have severe consequences. Johnny may not have even known that Linda was using her health coverage under the Fund after their divorce, but he and Linda are jointly responsible for this debt because they did not timely notify the Fund of their divorce. By not notifying the Fund, Johnny is risking his financial security and continued health coverage for himself and his children. **DO NOT** put yourself in a situation where you end up owing the Fund a significant amount of money and losing your coverage, as well as the coverage of your other family members, due to not reporting your divorce in a timely fashion.

Remember – While COBRA premiums are expensive, paying a monthly COBRA premium (after timely notifying the Fund of your divorce) is far less expensive than incurring personal liability for claims and losing your coverage.

Example – Johnny Carpenter's divorce judgment is signed by a judge on April 11, 2020. Under the rules of the Fund, Johnny's ex-spouse Linda's coverage under the Fund ends on April 30, 2020. (If notice of the divorce is provided within 60 days, Linda can elect COBRA coverage for up to 36 months.) However, neither Johnny nor Linda notifies the Fund of their divorce and as a result, Linda remains listed as a dependent.

In August of 2020, Linda is diagnosed with cancer. She immediately has surgery followed by radiation and chemotherapy treatments over the next several months, racking up $85,000 in medical claims, which are paid by the Fund since it had not been notified of the divorce. In January of 2021, Johnny finally notifies the Fund of his divorce at which time the Fund learns that it paid $85,000 in claims for which Linda was not eligible. Under the rules of the Fund, Johnny and Linda are now responsible for reimbursing the Fund $85,000.

Additionally, since the Fund was not notified of the divorce within 60 days, Linda no longer has the option of electing and paying for COBRA coverage. Johnny and his other dependents will immediately lose their Welfare coverage unless and until the full amount due is paid to the Fund, and legal action may be taken against Johnny and Linda to recover the claims paid in error.

Remember that even if your divorce judgment or settlement agreement requires you to pay some or all of the cost of your former spouse's health coverage after your divorce, this does not mean that your spouse remains eligible for coverage under the Fund unless COBRA is elected and paid for. Rather it means that you have financial responsibility for some or all of your former spouse's health care premiums after he/she is no longer eligible for coverage as your spouse.

If you have questions about removing an ex-spouse from your coverage after a divorce, please contact our Member Services Department at: (800) 529-FUND (3863).

ANNUAL REMINDER: "Breaks in Service" Can Impact Your Future Pension Benefits

Your service credit, pension calculation, and pension eligibility can be affected if your Covered Employment is interrupted before you have qualified for a vested benefit. The effect of such an interruption depends on whether the interruption is a "one-year break in service" or a "permanent break in service." In addition, even if you are vested, a one-year break in service can disqualify you from being eligible for a Disability Pension.

One-Year Break in Service You have a one-year break in service when you fail to earn at least one-quarter of a Vesting Credit (i.e., when you fail to work at least 300 hours) in a calendar year.

The following absences are not considered a break in service:

- Periods of qualified military service during which you are entitled to service credit under Section 414(u) of the Internal Revenue Code.
- Absence from work for maternity or paternity reasons due to pregnancy, the birth of your child, placement of a child with you in connection with an adoption, or to care for a child immediately following birth or adoption. Under this provision, up to one-quarter of a Vesting Credit is granted (i) in the year such absence begins, if necessary, to prevent a one-year break in service in that year, or (2) in the year following the year the absence began.
- If you receive a Disability Pension under this Plan, recover, and return to Covered Employment before the end of the third month following the last month for which you received a Disability Pension, a special rule may help prevent a break that would otherwise occur in the calendar year in which you return to Covered Employment. As long as you have at least 300 Hours of Service in the 12-consecutive-month period immediately following the date you returned from disability, you will not incur a one-year break in the calendar year of your return.
- Qualifying periods of absence of up to 12 weeks under the Family and Medical Leave Act (FMLA) will not constitute a break in service if you return to employment in the period required under the FMLA.

Unless one of the rules above applies, periods of disability will **NOT** prevent a break in service.

Remember, if you have a one-year break in service ***before*** becoming vested, you will no longer be an Active Participant in the Plan. If you have a one-year break in service ***after*** becoming vested, you will no longer be an Active Participant in the Plan, but you will be a Deferred Vested Participant.

A one-year break in service may be temporary and subject to repair. If you return to Covered Employment and earn at least 870 Hours of Service within any two consecutive calendar years before you have a "permanent break in service", your previously earned Vesting Credits and Benefit Credits will be restored.

One-Year Break in Service Example:

John started working in February 2014 and became a Plan Participant on January 1, 2015 after working 870 hours in 2014. John earned 3 Vesting Credits between January 1, 2015 and December 31, 2017. John did not work at least 300 hours in 2018 which resulted in a one-year break in service as of December 31, 2018.

If John returns to work and earns 870 hours over a consecutive two-year period ***before*** he has a permanent break in service, he will again become a Plan Participant and recover the 3 Vesting Credits earned.

Permanent Break in Service If you have a permanent break in service, you will forfeit all of your Vesting Credits and Benefit Credits, and you will not be eligible to have that service restored.

If you have at least one Hour of Service on or after January 1, 1999, you have a permanent break in service if you have five or more consecutive one-year breaks in service and had earned fewer than five Vesting Credits before the break began.

If you do **NOT** have at least one Hour of Service on or after January 1, 1999, you have a permanent break in service if:

- You have earned fewer than five Vesting Credits and have five consecutive one-year breaks in service, or
- You have earned at least six but fewer than ten Vesting Credits and the number of one-year breaks in service equals or exceeds the Vesting Credits earned before the break.

When you have a permanent break in service, you permanently lose all Vesting Credits and Benefit Credits (and/or credit earned under the benefit formula) earned before the break and your participation is cancelled. Your service credit cannot be restored even if you later become a Plan Participant.

Permanent Break in Service Example: Phil started working in March 2011 and became a Plan Participant on January 1, 2012 after working 870 hours in 2011. Phil earned 2 Vesting Credits between January 1, 2012 and November 12, 2014. Phil did not work at least 300 hours in 2015 which resulted in a one-year break in service and he did not return to covered employment for the next 5 consecutive years. Because Phil incurred five consecutive one-year breaks in service, as of December 31, 2019, he permanently lost the 2 Vesting Credits earned. Phil's credit cannot be restored even if he becomes a Plan Participant again in the future.

If you have questions concerning breaks in service and how they may impact your pension, you can view the Summary Plan Description on the Benefit Funds' website at:
www.nyccbf.com/wp-content/uploads/2016/06/Pension-SPD.pdf
or you can call Member Services at (800) 529-FUND (3863).

THE NYCCBF MEND PROGRAM

The New York City District Council of Carpenters Welfare Fund has launched the Members Education and Network for Dependency ("MEND") Program, which gives participants and their dependents access to confidential treatment for substance abuse and mental health issues.

Services include:

- Referrals to appropriate level of treatment including inpatient and outpatient treatment for all substances and mental health issues,
- Case management and Coordination of Services with outside providers,
- Supportive services and Education.

If you or one of your dependents is struggling with substance abuse or mental health issues, please contact the MEND Program for assistance from our accredited staff. The MEND program can be reached at:

Phone: (212) 366-7590
Email: MEND@nyccbf.org

IMPORTANT NOTICE: Medicare Enrollment Responsibilities, Retiree Welfare Coverage, and YOU

If you and/or your covered dependent(s) are (or become) eligible for Medicare, and you have Retiree coverage under the NYCDCC Welfare Fund (the "Welfare Fund") or you are about to transition from Active coverage to Retiree Coverage, you **MUST** enroll in both **Medicare Part A** and **Medicare Part B** in order to have any Retiree coverage. You should enroll in Medicare as soon as Medicare coverage becomes available if you want to maintain your Retiree coverage. If you do not enroll in both Medicare Part A and Part B, you will not be covered through UnitedHealthcare or Empire, **resulting in higher out-of-pocket costs and/or loss of coverage for you**. This includes members who retired before age 65 on a Regular Pension and later become eligible for Social Security prior to age 65.

When you and/or your covered dependent(s) become eligible for Medicare, your Welfare Fund coverage changes. In order to avoid a loss of coverage or denial of benefits, you must send us copies of your Medicare cards. This can be done in the following ways:

In Person: At Fund Office, 9th Floor

Mail: NYCDCC Benefit Funds
Attn: Member Services
395 Hudson Street, 9th Floor
New York, NY 10014

Fax: (212) 366-7845

Email: **MemberServices@nyccbf.org**
(*PDF attachments of copy only. Images/pictures of the card will not be accepted.)

If you have questions about the Medicare enrollment process and your responsibilities concerning continued Welfare Fund coverage, please contact our Member Services Department at **(800) 529-FUND (3863) or (212) 366-7373**.

SUMMARY OF MATERIAL MODIFICATIONS
Important Information Regarding Your Health Benefits
Effective July 1, 2022

This document is a Summary of Material Modifications ("SMM") intended to notify you of an important change made to medical and prescription drug benefits of the NYC District Council of Carpenters Welfare Fund (the "Welfare Fund" or "Fund"). You should take the time to read this SMM carefully and keep it with a copy of the Welfare Fund's Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes, please contact the Fund Office.

Dear Participant:

The Board of Trustees is pleased to announce that, effective **July 1, 2022,** the Fund is implementing a number of improvements to the Plan to comply with the No Surprises Act (the "NSA"). This SMM advises you of changes to certain Welfare Fund benefits pursuant to the NSA.

The NSA was signed into law in December 2020 and protects patients from "balance billing" for Out-of-Network emergency services, Out-of-Network air ambulance services, and certain non-emergency services performed by an Out-of-Network provider at an In-Network facility (collectively "No Surprise Services"). For the Welfare Fund, the protections described in this SMM apply to claims incurred for No Surprises Services on and after July 1, 2022.

You are still encouraged to use In-Network facilities and participating providers whenever possible. Please review these changes carefully and contact the Fund Office with any questions that you may have.

Effective July 1, 2022, Participants and Dependents receiving No Surprises Services will only be responsible for paying their In-Network cost sharing, and cannot be balance billed by the provider or facility for emergency services.

Emergency Services The NSA requires emergency services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;
2. Without regard to whether the health care provider furnishing the emergency services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;
3. Without imposing any administrative requirement or limitation on Out-of-Network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from In-Network Providers and In-Network emergency facilities;
4. Without imposing cost-sharing requirements on Out-of-Network emergency services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;
5. By calculating the cost-sharing requirement for Out-of-Network emergency services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and
6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider.*

* *The Fund already applies the same cost-sharing provisions to emergency services regardless of whether they are provided In-Network or Out-of-Network.*

Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

The No Surprises Act requires non-emergency services performed by an Out-of-Network Provider at an In-Network Health Care Facility to be covered as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network Provider;
2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the recognized amount for the items and services; and
3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Welfare Fund in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.
4. **Notice and Consent Exception:** Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:
   a. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Welfare Fund, the estimated charges for your treatment and any advance limitations that the Welfare Fund may impose on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and
   b. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Out-of-Network Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Welfare Fund from an Out-of-Network provider, those services will be covered by the Welfare Fund as follows:

- The Air Ambulance services received from an Out-of-Network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network provider.

Continuity of Coverage

If you are a Continuing Care Patient (see the definitions at the end of this SMM), and the Fund terminates its In-Network contract with an In-Network provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the network:

- You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to ninety (90) days of continued coverage at In-Network cost sharing to allow for a transition of care to an In-Network provider.

Incorrect In-Network Provider Information

A list of In-Network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Fund or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is an In-Network provider from the Fund or its administrators, the Fund will apply In-Network cost-sharing to your claim, even if the provider was an Out-of-Network provider at the time the service was rendered.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office at (800) 529-FUND (3863) or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

External Review Process of Certain Coverage Determinations

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by an Out-of-Network provider at an In-Network facility, and/or Air Ambulance service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Fund's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

New Definitions Implemented from the NSA

To implement the protections of the No Surprises Act, the Board of Trustees of the Fund is adopting the following new/revised definitions of terms in the Plan/SPD, effective July 1, 2022.

Ancillary Services means, with respect to a participating health care facility, the following:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services; and
4. Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a "serious and complex condition"; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Serious impairment to bodily functions; or
2. Serious dysfunction of any bodily organ or part; or
3. Placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
3. Emergency services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post-stabilization services (i.e., services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:
    a. The provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and
    b. You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Welfare Fund, of the estimated charges for your treatment and any advance limitations that the Welfare Fund may put on your treatment, of the names of any In-Network Providers at the

facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

c. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

Health Care Facility (for non-emergency services) means each of following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

No Surprises Services means the following, to the extent covered under the Welfare Fund:

1. Out-of-network Emergency Services;
2. Out-of-network Air Ambulance services;
3. Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at an in-network facility; and
4. Other out-of-network non-emergency services performed by an out-of-network provider at an in-network health care facility with respect to which the provider does not comply with federal notice and consent requirements.

Recognized Amount means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount ("QPA").

For Air Ambulance services furnished by Out-of-Network providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

Qualifying Payment Amount or QPA means generally the median contracted rates of the Fund or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR § 716-6(c).

Serious and Complex Condition means one of the following:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
2. In the case of a chronic illness or condition, a condition that is the following:

a. Life-threatening, degenerative, potentially disabling, or congenital; and

b. Requires specialized medical care over a prolonged period of time.

Please keep this important notice with your SPD for easy reference to all Plan provisions. If you have any questions, you may also call the Fund Office.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Welfare Fund's benefits. The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Welfare Fund, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Welfare Fund. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Welfare Fund, make any promises to you about benefits under the Welfare Fund, or to change any provision of the Welfare Fund. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Welfare Fund and decide all matters, legal and/or factual, arising under the Welfare Fund.

NYCDCC Benefit Funds Launches Accessibility Widget for Website

The NYCDCC Benefit Funds has an accessibility widget for our website. The widget, which comes by way of AccessiBe and can be located on the bottom right corner of your computer/ smartphone screen, assists website visitors in experiencing content in the most optimal way possible based on individual needs. The widget helps those who are vision or hearing impaired, have seizure conditions, have cognitive disabilities, or have attention deficit disorders select from a variety of features that enhance their experience with the website.

Options offered by the AccessiBe widget include content scaling, adjusting font sizes, changing colors, eliminating animation or flashing lights, allowing for text-to-speech capabilities, highlighting specific areas of text, and much more.

Check it out by visiting our website at **www.nyccbf.org**.

Don't Forget to Complete your

Charles Johnson Jr. Memorial Scholarship Application

by December 15th

If you have a child about to head into college (his/her senior year of high school), don't forget that the NYCDCC Welfare Fund offers a Scholarship Program (known as the "Charles Johnson Jr. Memorial Scholarship") for unmarried, dependent, biological, or adopted children of eligible members. The Scholarship Program pays up to $3,500 for each year of a four-year academic program at an accredited college or university, or until the child receives a bachelor's degree, whichever occurs first. The maximum amount of the award is $14,000 per student. Currently, 25 students are selected to receive scholarships each year.

If you are interested in applying for a Charles Johnson Jr. Memorial Scholarship for your child, you must submit the application by December 15th. You can fill out an application by visiting the Scholarship section of our website at: **https://nyccbf.com/member/scholarship-benefit/** and clicking the link to the International Scholarship and Tuition Services' ("ISTS") website. You may also visit the ISTS website directly at: **https://aim.applyists.net/NYCDCC.**

Notice of Availability of HIPAA Privacy Notice

In accordance with the Privacy Rule under the Health Insurance Portability and Accountability Act ("HIPAA"), the New York City District Council of Carpenters Welfare Fund (the "Fund") follows certain procedures to protect the privacy of your Protected Health Information ("PHI") maintained by the Fund. The Fund's Privacy Notice describes how the Fund uses and discloses PHI and discusses your rights regarding your PHI.

You can access the Fund's Privacy Notice by visiting:
www.nyccbf.org/wp-content/uploads/2016/06/WF-Privacy-Notice_Revised-as-of-October-2022.pdf

You may also request a copy of the Privacy Notice by submitting a written request to the:
Fund Office – 395 Hudson Street, 9th Floor, New York, NY 10014

TOOL TIME

Notes & Reminders

COMPLIANCE AND ETHICS PROGRAM

Report Misconduct, Fraud, Waste, or Abuse The New York City District Council of Carpenters Benefit Funds ("Benefit Funds") strive to maintain the highest standards of ethics and conduct in all aspects of Funds operations. As a tangible commitment to this ideal, the Board of Trustees has adopted and implemented a Compliance and Ethics Program ("CEP"). The CEP sets forth standards for the guidance of all Benefit Funds staff in the day-to-day business of administering benefits for all members.

Reporting You can contact the Chief Compliance Officer of the Benefit Funds if you have a question or concern regarding the appropriateness or legality of a Benefit Funds' policy, procedure or transaction. All of us – Benefit Funds staff, the Trustees and Funds members - are responsible for ensuring that Funds assets are reserved to pay only for covered benefits and the reasonable costs of administering those benefits. We all share a duty to protect against violations of law and Benefit Funds rules. So, if you see or suspect something, say something.

Please report any matter that may constitute a breach of applicable laws, rules, regulations or Benefit Funds' policies to Allan Bahn, the Benefit Funds Chief Compliance Officer. You can provide your name or remain anonymous. All information will be considered confidential. The Chief Compliance Officer can be contacted via:

Mail:

Allan Bahn
Chief Compliance Officer
New York City District Council of Carpenters Benefit Funds
395 Hudson Street, 9th Floor,
New York, New York 10014

Work Phone:
(212) 366-7533

Confidential Hotline:
(646) 484-1665

Email:
ABahn@nyccbf.org
Complianceandethics@nyccbf.org

Website: Visit **www.nyccbf.org** and click on the "Report a Compliance Issue" link located at the bottom of the screen.

Women's Health and Cancer Rights Act ("WHCRA") **ANNUAL NOTICE – 2022**

The NYCDCC Welfare Fund, in accordance with the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. If you would like more information on these benefits, please contact us at: (212) 366-7300 or (800) 529-FUND (3863).

New York City District Council of Carpenters
BENEFIT FUNDS
395 Hudson St. 9th fl.
New York, NY 10014

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Permit No. 125

Statement of Nondiscrimination

The New York City District Council of Carpenters Welfare Fund (the "Welfare Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

*The New York City District Council of Carpenters Welfare Fund cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

*The New York City District Council of Carpenters Welfare Fund 遵守適用的聯邦民權法律規定, 不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

The New York City District Council of Carpenters Benefit Funds

Contact Information

New York City District Council of Carpenters Benefit Funds
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* The information in this newsletter is intended to highlight certain information about your benefits and the Benefit Funds. Benefits Toolbox is not a substitute for the official Plan documents which set forth the requirements and conditions for benefits. In the event of an inconsistency or a conflict between Benefits Toolbox and the Plan documents, the Plan documents shall control.