carpenters'
benefit plans
HEALTH & RETIREMENT SERVICES

Plan Document and Summary Plan Description

Restated as of:

January 1, 2021

Introduction

The legal name for the health plan outlined in this Plan Document and Summary Plan Description is Carpenters' Health and Welfare Trust Fund of St. Louis. This name is used only for legal filing purposes. Throughout this document and in other health plan materials, Carpenters' health plan may also be included in reference to or referred to as:

1. Carpenters' Benefit Plans. *Carpenters' Benefit Plans* is a plan reference that includes the health, vacation, annuity and St. Louis pension plans.
2. St. Louis-Kansas City Carpenters Regional Health Plan
3. Carpenters Health Plan
4. The Plan

Definitions

Plan definitions are included in Section XII. A capitalized word within the Plan Document indicates a definition will appear in Section XII.

Section I

Eligibility & Enrollment

This Section I sets forth the rules for determining eligibility for all benefits under the St. Louis-Kansas City Carpenters Regional Health Plan (Plan) except Safety Enhancement Benefits under Section VII. In addition, eligibility for Short-Term Disability Benefits and Life and Accidental Death and Dismemberment Insurance is subject to additional limitations set forth in Sections VI and VII.

A. Eligible Employee Groups

1. **Collectively Bargained Employees** covered by a Collective Bargaining Agreement requiring contributions to this Plan.
2. **Carpenters Regional Council (regional council) Employees** who are carried on the payroll of the St. Louis-Kansas City Carpenters Regional Council if each of the following conditions are met:

   (a) Receive a Form W-2 issued by the regional council (including such employees who perform some or all their duties for benefit plans sponsored by the regional council); and

   (b) Work, on average, not less than thirty (30) hours per work week; and for whom the regional council has executed a participation agreement on terms acceptable to the Trustees. This includes any and all benefit plans sponsored by the regional council when they are acting in the capacity of an Employer.

   Eligibility for such employees will be based on Uncapped Credit Hours as in the case of Hours-Based Eligibility in Section I.C.1.(a), and contributions will be paid by the regional council at the same hourly rate as the current journeyman level hourly Employer contribution specified in the labor agreement under which most contributions are paid. Except as may be otherwise expressly provided, these Members and their eligible Dependents are entitled to the same benefits, eligibility, and Non-Active Classification options as Members in the Hours-Based Eligibility class.

3. **Retired employees** for whom the regional council was the recognized bargaining representative when they were actively working, or who were employees described in paragraph 2 above.

4. **Non-Bargained Office Employees** of **Signatory Employers** if each of the following conditions is met:

   (a) The Employer must have a Collective Bargaining Agreement with the regional council requiring contributions to this Plan; and

      1) The Employer must either:

         a) Have at least one employee regularly employed who is covered by the Employer's Collective Bargaining Agreement, or

         b) Regularly perform, through subcontractors, work that would be covered by the Employer's Collective Bargaining Agreement if performed by the Employer's own employees and must also agree to subcontract such work only to subcontractors who are contractually bound to contribute to this Plan on behalf of employees who perform such work.

   (b) The Employer must execute a participation agreement for Non-Bargained Office Employee coverage on terms acceptable to the Trustees; and

   (c) The Employer must be accepted by the Trustees in their discretion; and

   (d) The Employer must agree to contribute, at the times and monthly rates established by the Trustees from time to time, on behalf of the Employer's non-collectively bargained employees who work (in

an office or elsewhere) 30 or more hours per week or an average of 130 hours or more per month as defined in Section 4980H(c)(4) of the Code and at the Employer's option, may also agree to contribute for all such employees who work fewer hours than specified above. Non-Bargained Office Employee coverage for any or all Employers may be terminated by the Trustees at any time.

5. **Other** groups of individuals for whom contributions may be made under agreements acceptable to the Trustees such as a Self-Employed agreement.

B. Initial Enrollment

All Eligible Employees Groups must complete and sign an Enrollment Form accepted by the Plan before becoming a Member and receiving benefits under this Plan.

C. Eligibility Classifications

1. **Active Classification**

A Member is in the Active Classification if the Member's eligibility results from:

- Employer contributions for the Member's Active Work, or
- The Member's Minimum/Difference self-payments, or
- The Member's COBRA self-payments, or
- The Member's Self-Employed contribution.

(a) **Eligibility Classes within the Active Classification**

There are two Eligibility Classes under the Active Classification:

1) Hours-Based Eligibility is composed of Members who are credited with one or both of the following:

a) Uncapped Credit Hours: Credit Hours credited by an employer who is required to make contributions to this Plan for all hours worked and for reasons other than hours worked.

b) Capped Credit Hours: Credit Hours credited by an employer who is required to make contributions to this Plan up to a maximum per month as expressed by the journeyman level in the Collective Bargaining Agreement.

2) Monthly Eligibility is composed of Members who are Non-Bargained Office Employees with respect to whom monthly Employer contributions are required and received, or Members who are Self-Employed individuals with respect to whom monthly Self-Employed contributions are required and received.

(b) **Initial Eligibility within the Active Classification**

1) Hours-Based Eligibility

An employee initially becomes eligible for benefits in the Hours-Based Eligibility Class on the first day of the month following the employee's completion of a total of at least 500 Capped and Uncapped Credit Hours or 250 Capped Credit Hours during the preceding six consecutive months.

2) Monthly Eligibility

An employee initially becomes eligible for benefits in the Monthly Eligibility Class on the first day of the month following the month in which the first timely contribution is received.

(c) **Continuing Eligibility within the Active Classification**

1) Hours-Based Eligibility Class

A Member who has established Hours-Based Eligibility will continue to be eligible based on Benefit Quarters that follow Contribution Quarters. Benefit Quarters begin each January 1, April 1, July 1, and October 1, as shown on the following chart:

CONTRIBUTION QUARTER **Hours Worked**	**Provides Coverage For**	***BENEFIT QUARTER*** **Eligibility Period**
August, September, October	➔	January, February, March
November, December, January	➔	April, May, June
February, March, April	➔	July, August, September
May, June, July	➔	October, November, December

a) Quarterly Rule: A Member who receives a total of at least 300 Capped and/or Uncapped Credit Hours in a Contribution Quarter, will have eligibility extended through the Benefit Quarter that next follows that Contribution Quarter.

b) Look Back Rule: A Member who receives a total of at least 1,200 Capped and/or Uncapped Credit Hours during a 12 consecutive-month period ending with any month in a Contribution Quarter, will have eligibility extended through the Benefit Quarter that next follows that Contribution Quarter.

c) Plan Year Rule: A Member who receives at least 1,300 Uncapped Credit Hours in a Plan Year (May 1 – April 30), will have eligibility extended until the end of March of the following year.

d) Extension of Hours-Based Eligibility for Disability: If a Member is unable to accrue sufficient Credit Hours to maintain eligibility due to an occupational or non-occupational Total Disability, and has accrued a total of at least 1,300 Capped and/or Uncapped Credit Hours during the 12-consecutive months ending with the month in which the Total Disability began, the Member's eligibility in the Hours-Based Eligibility Class will be automatically continued, without contributions, until the earlier of:

i. The date the Member's Total Disability ends,
ii. The date the Member returns to work, or
iii. The last day of the Benefit Quarter containing the first anniversary of the date the Member's Total Disability began.

e) Temporary Eligibility Provisions

i. Temporary eligibility provisions are set forth in Appendix G.

2) Monthly Eligibility Class

Continuing eligibility of a Member in the Monthly Eligibility Class is determined on a month-to-month basis. A monthly contribution required, due and received in one month maintains the Member's eligibility for the following month.

(d) **Termination of Active Classification**

Notwithstanding any provision herein to the contrary, the Member's coverage and benefits will end on the earliest of the following dates unless an available self-pay option is elected:

1) The last day of eligibility earned by the Member's Credit Hours or Monthly Contribution.
2) The date a Member is found to have engaged in employment in the construction industry by an Employer who is not obligated to contribute to the Plan.
3) The date of the Member's death.
4) The date the Member falsifies any information in connection with coverage, a claim for benefits or commits any action with the intent to defraud the Plan.
5) The date a Member is eligible for Medicare that is primary to the Plan, but is not enrolled in both Medicare Part A and B. An Active Classification Member's Medicare coverage is primary to this Plan if:
    a) The Member is employed by a "small Employer" within the meaning of the Medicare regulations, or
    b) The Member had 30 months of secondary Medicare coverage on account of End-Stage Renal Disease and Medicare is now primary to this Plan, except if the Member's eligibility is based on COBRA continuation coverage.
6) The date a Member's Employer is no longer obligated to contribute to this Plan.
7) The date the Plan terminates.

In addition, eligibility of a Member in the Carpenters Regional Council Employees Group will end on the last day of the month in which the Member's employment by the regional council terminates for any reason other than the Member's Total Disability within the meaning of this Section I.C.2.(h) below or the Member's retirement while eligible to receive pension benefits from one of the associated Carpenters' Pension Plans.

Eligibility of a Member that would otherwise terminate pursuant to the foregoing termination provisions will nevertheless continue to the extent required under the terms and conditions of the Family and Medical Leave Act of 1993 and the Uniformed Services Employment and Reemployment Rights Act of 1994. If a covered person becomes absent from employment by reason of service in the uniformed services, and would otherwise lose coverage on account of such absence, he or she may elect to continue coverage in the Plan as provided in 38 USC section 4317(a) pursuant to Appendix H of this Plan Document.

(e) **Reinstatement Provisions – Active Member Classification**

A Member who has lost coverage in the Active Member Classification, and is not participating as a self-pay Member in the Non-Active Classification, may reinstate the lost Active Classification coverage by either of the following conditions:

1) Accruing the required number of credit hours in a Contribution Quarter under the Continuing Eligibility rules, provided these credit hours would result in continuing eligibility commencing within one year of the Member's termination of coverage date. The reinstated coverage becomes effective on the first day of the next Benefit Quarter.
2) A monthly contribution for such Member is required, made, and received by the Plan. The Member's coverage will be reinstated on the first day of the month following the month in which the contribution is received by the Plan.

A Member who lost coverage and does not qualify for reinstated coverage under the previous paragraphs, must again satisfy the Initial Eligibility requirements to regain Active coverage.

(f) **Self-Payment Provisions – Active Member Classification**

1) Maintaining Coverage: A Member who no longer qualifies for Continuing Eligibility may maintain continuous coverage for a limited period of time by electing, to the extent available, a self-pay option.

a) Hours-Based Eligibility Class
Members in the Hours-Based Eligibility class can elect either Minimum/Difference self-payments or COBRA continuation coverage. These options are mutually exclusive, and an election of one is a waiver of the other with respect to that loss of coverage. Election of either option does not prevent the Member from regaining Active Classification coverage through Credit Hours under the provisions of Continuing Eligibility and Reinstatement Provisions above.

b) Monthly Eligibility Class
Members in the Monthly Eligibility class can elect COBRA continuation coverage only.

2) Not Eligible for Self-Payment Provisions: Certain Members in the Hours-Based Eligibility Class are not eligible to initiate or continue coverage through Minimum/Difference payments, as described below:

a) Members who are the owners, partners, members, directors or officers of a Contributing Employer or its affiliate(s) who are delinquent for more than one month in contributions to this Plan or to a Carpenters' Pension Plan.

These Members are eligible to replace existing Minimum/Difference coverage with COBRA coverage for the remainder of the period for which COBRA coverage could have been elected instead of Minimum/Difference coverage.

b) Members who are found to have engaged in employment in the construction industry by an employer who is not obligated to contribute to this Plan.

c) Members in the Carpenters Regional Council Employees group unless the employee is:

1. Totally and Permanently Disabled, or
2. Retiring and receiving a pension benefit from an associated Carpenters' Pension Plan.

3) Minimum/Difference Self-Payments
If a Member described in Subsection f (Self-Payment Provisions) has earned less than 300 credit hours in a Contribution Quarter, and for that reason would otherwise lose Active Classification eligibility in the corresponding Benefit Quarter, the Member may elect to maintain continuous Active Class eligibility by making self-payments directly to the Fund (Minimum/Difference payments). If a Member makes a timely Minimum/Difference payment for a Contribution Quarter in the required amount, the Member's eligibility will be extended through the corresponding Benefit Quarter.

a) Rate for Coverage
The required amount of a Member's Minimum/Difference payment for a Benefit Quarter is equal to the difference between 300 and the number of credit hours received for that Member in the corresponding Contribution Quarter, multiplied by the current journeyman level hourly Employer contribution specified in the labor agreement under which most

contributions are paid. If no Credit Hours were earned, the payment amount is equal to the Employer contribution required for the minimum 300 credit hours.

b) Duration of Coverage

Coverage maintained by Minimum/Difference payments must be continuous, beginning with the first Contribution Quarter in which a Member has earned less than 300 Credit Hours. A Member may maintain Active Classification coverage by Minimum/Difference payments for no more than six consecutive Benefit Quarters (18 months). A Member who ends a period of coverage maintained by Minimum/Difference payments may not begin a new period of coverage maintained by Minimum/Difference payments until the Member has at least two consecutive quarters of Active Classification coverage earned solely with Credit Hours.

c) Minimum/Difference and COBRA

Election of Minimum/Difference payments is an alternative to election of COBRA. COBRA continuation coverage is not available to a Member who loses coverage at the end of one or more quarters of Minimum/Difference payments. If a Member exhausts the maximum permissible period of coverage by making Minimum/Difference payments, the Member can regain Active Classification coverage only by satisfying the Continuing Eligibility or Reinstatement Provisions. Alternatively, coverage may be maintained in the Non-Active Classification if the Member qualifies.

d) Payment Options

A Minimum/Difference payment for a Benefit Quarter may be paid in one payment for the entire quarter of coverage or, at the Member's option, may be paid in monthly installments. If paid quarterly, the full payment amount is due on the first day of the month prior to the applicable Benefit Quarter and must be received by the Fund within 15 days of the due date to be accepted. The payment schedule for quarterly payments is shown in the following table:

BENEFIT QUARTER FOR COVERAGE	PAYMENT DUE
January, February, March	December 1
April, May, June	March 1
July, August, September	June 1
October, November, December	September 1

If the monthly installment option is selected, a recurring, automatic method of payment must be provided for all three installment due dates. The amount due each month is one-third of the total payment due for the Benefit Quarter. Monthly payments are due on the first day of the month prior to the applicable month of coverage and must be received by the Plan within 15 days of the due date to be accepted. If your automatic payment is insufficient and payment is not made within the time for acceptance, coverage will end on the last day of the month for which coverage has been paid. The payment schedule for monthly payments is shown on the following table:

MONTH OF COVERAGE		PAYMENT DUE/CHARGE DATE
First Quarter:	January	December 1
	February	January 1
	March	February 1
Second Quarter:	April	March 1
	May	April 1
	June	May 1
Third Quarter:	July	June 1
	August	July 1
	September	August 1
Fourth Quarter:	October	September 1
	November	October 1
	December	November 1

Coverage maintained by Minimum/Difference payments will end on the earliest of the following dates:

1. The date the Member's maximum period of Minimum/Difference coverage ends; or
2. The last day of the period for which the Member made his most recent timely payment; or
3. The last day of the month before the month in which the Member first becomes Eligible for Medicare; or
4. The date a Member is found to have engaged in employment in the construction industry by an employer who is not obligated to contribute to this Plan; or
5. The date of the Member's death; or
6. The date the Member falsifies any information in connection with coverage or a claim for benefits or commits any action with the intent to defraud the Plan; or
7. The date the Plan terminates.

4) COBRA Self-Payments

An Active Member in any of the Eligibility Classes who would otherwise lose coverage (and, in the case of a Member in the Hours-Based Eligibility Classes, has not elected an available Minimum/Difference payment) may elect COBRA continuation coverage under the terms and conditions set forth in Section I.E. below. COBRA coverage that begins immediately following a period of Active coverage is considered a continuation of Active coverage for purposes of the Plan, unless otherwise provided.

2. **Non-Active Classification**

The Non-Active Classification allows qualified Members and their Dependents to continue coverage under the Plan through self-payments, after they no longer meet the requirements of the Active Classification. To be eligible for coverage in the Non-Active Classification, a Member must have previously been in the **Hours-Based Eligibility Class** or **Monthly Eligibility Class for Self-Employed Members** and must satisfy the additional requirements, set forth in this Subsection (c)-(h) below, of one of the following five categories:

- Retired Members
- Retired Self-Employed Members
- Non-Pension Members
- Disabled Members
- Surviving Spouses

(a) **Non-Active Classification Benefits**

Provided the applicable Premium is paid, benefits provided to Members in the Non-Active Classification and their Dependents are the same as those provided under the Active Classification, except as follows:

1) Non-Active Plan Benefits for Medicare-Eligible Individuals

   If an individual Member or Dependent covered in the Non-Active Classification becomes eligible for Medicare, that individual will cease to be eligible for any benefit from the Plan. If, upon becoming Eligible for Medicare, such individual elects to enroll immediately in the UHC Medicare Advantage Program described in Subsection (e) below, the individual will remain eligible, while enrolled in the UHC Medicare Advantage Program, for the Plan's Life and Accidental Death benefit (Member only for Accidental Death benefit), and will also have the option to remain eligible for the Plan's dental benefits at an increased Premium. If a Member enrolls in the UHC Medicare Advantage Program, the Member will also have the option, while so enrolled, to maintain family coverage in the Non-Active Classification for his or her Dependents by payment of the applicable Premium.

2) Short-Term Disability Benefits

   Members who become disabled while covered in the Non-Active Classification are not eligible to receive Short-Term Disability benefits.

3) Dental Benefits

   Members covered in the Non-Active Classification, and Members or Dependents enrolled in the UHC Medicare Advantage Program, have the option to purchase the dental benefits of the Plan for an additional Premium. Such persons must enroll for optional dental benefits at the time they first enroll in the Non-Active Classification, or in the UHC Medicare Advantage program, respectively; otherwise, they must wait for the next Open Enrollment period of October 1 through December 15. If dental benefit coverage is dropped after having been elected, it may not be reinstated.

(b) **Dependent Coverage**

Members covered in the Non-Active Classification have the option to purchase single coverage (for the Member only), or family coverage (for the Member and Dependents) at a higher Premium. Except as provided for Surviving Spouses, a Member's Dependent cannot be covered in the Non-Active Classification unless the Member is covered.

An election of single coverage in the Non-Active Classification is irrevocable except a Non-Active Member has the option to elect family coverage as follows, provided the Dependent meets all other enrollment requirements of the Plan:

1) A Spouse who opted out of coverage in this Plan and thereafter maintained continuous health coverage through the Spouse's employer and that coverage did not terminate more than 63 days before the requested date for beginning Non-Active coverage in the Plan, or

2) A newly acquired Dependent can request enrollment within 30 days of the special Qualifying Event.

(c) **Self-Payment Premium Requirements**

Coverage of Members and Dependents in the Non-Active Classification requires self-payment of a monthly contribution (Premium), to be paid directly to the Plan, as determined and published periodically by the Trustees. Contribution amounts vary under each category depending upon the coverage selection.

Monthly contributions for coverage are due on the first day of the month prior to the month of coverage and must be received in the Plan Office within 15 days of the due date to be accepted.

(d) **Carpenters Regional Council Affiliation Requirement**

As a condition of eligibility for benefits under the Non-Active Classification, all members (except Surviving Spouses and Carpenters Regional Council Employees), including Retired Self-Employed, Non-Pension and Disabled Members, must maintain membership with the St. Louis – Kansas City Carpenters Regional Council or its affiliated Locals at all times to be eligible for Non-Active coverage.

(e) **Medicare Eligible Members and Dependents: UHC Group Medicare Advantage Program**

As stated in this Subsection (a).1) above, a Member or Dependent who becomes eligible for Medicare while covered in the Non-Active Classification ceases to be eligible for Plan benefits if no further action is taken. To assist such individuals' transition to Medicare, the Plan has arranged for UnitedHealthcare to offer the UHC Medicare Advantage Program, at Premium rates and with attractive benefits. The UHC Medicare Advantage Program is a group or group-type insurance program offered by an insurer to provide Medicare Part C benefits and is available only to individuals who become eligible for Medicare while covered in the Plan's Non-Active Classification.

Benefits provided in the UHC Medicare Advantage Program are not Plan benefits; they are provided independently under an insurance contract in return for the Premium charged by United Healthcare. The role of the Plan is to collect and remit monthly Premiums to UnitedHealthcare on behalf of individuals who choose to participate, and to report to UnitedHealthcare the individuals who have paid such Premiums. The Plan's monthly charge for an individual who participates in the UHC Medicare Advantage Program includes 100% of the Premium due from the individual to UnitedHealthcare.

The Plan does not endorse the UHC Medicare Advantage Program, or pay any part of its cost, or require its use. Participation in the UHC Medicare Advantage Program is strictly voluntary, at the option of an individual who becomes eligible for Medicare while covered in the Plan's Non-Active Classification. Such an individual may instead choose only conventional Medicare (Parts A and B), or Medicare plus private supplemental insurance, or a different Medicare Advantage plan. However, enrollment in a different Medicare Advantage plan, or in Medicare Part D, will preclude or terminate participation in the UHC Medicare Advantage Program.

To participate in the UHC Medicare Advantage Program, an individual must also be enrolled in Medicare Parts A and B, and must enroll in the UHC Medicare Advantage Program, either prior to the individual's Medicare Effective date or no later than 60 days after first becoming eligible for Medicare, to be accepted. An election to maintain optional benefits under the Plan must be made at the same time. A Member's Dependent may participate in the UHC Medicare Advantage Program only if, and so long as, the Member has elected family coverage.

While covered in the Active Classification, Members or Dependents do not lose Plan eligibility on account of becoming eligible for Medicare; however, they are not eligible to enroll in the UHC Medicare Advantage Program unless they qualify and become covered in the Non-Active Classification.

(f) **Retired Members**

For purposes of eligibility for coverage in the Non-Active Classification, a "retired member" is an individual (1) who has begun to receive pension benefits from any of the Carpenters' Pension Plans, (2) who had a previous period of coverage in the Hours-Based Eligibility Class, and (3) who is neither a retired Self-Employed Member, a retired Non-Pension Member, a Disabled Member, nor a Surviving Spouse.

1) A Retired Member first becomes eligible for Non-Active retiree coverage on the date the Member begins to receive such pension benefits unless, on that date, the Member is entitled to an additional period of Hours-Based Eligibility, or a prior election of Minimum/Difference or COBRA coverage. In such cases, the Retired Member first becomes eligible for Non-Active retiree coverage at the end of such extended period of Active Classification coverage.
2) A Retired Member can enroll in Non-Active retiree coverage only if:
    a) The Member elects such coverage within 63 days after first becoming eligible pursuant to subparagraph 1) above; and
    b) Has at least 120 months, in any combination, of:
        1. Months in which the Member performed bargaining unit work for an Employer signatory to a Collective Bargaining Agreement with the regional council but was not required to contribute to this Plan, or
        2. Months of coverage in the Hours-Based Eligibility Class earned by contributions to this Plan by a contributing Employer including months of coverage by COBRA or Minimum/Difference payments; and
    c) At least 36 months of said 120 months were earned during the 5 years immediately preceding election of Non-Active coverage.
3) An individual who loses Active eligibility in the Hours-Based Eligibility Class as a result of employment, while in a non-bargaining unit position, by an Employer obligated by a Collective Bargaining Agreement with the regional council to contribute to this Plan for bargaining unit employees, and who remains covered in a group health plan during such employment, and who becomes a Retired Member during or at the end of such employment, can enroll in Non-Active retiree coverage only if:
    a) The Member elects such coverage within 63 days after first becoming eligible pursuant to Subsection (f) above.; and
    b) Has at least 120 months, in any combination, of:
        1. Months in which the Member performed bargaining unit work for an Employer signatory to a Collective Bargaining Agreement with the regional council but was not required to contribute to this Plan, or
        2. Months of coverage in the Hours-Based Eligibility Class earned by contributions to this Plan by a contributing Employer including months of coverage by COBRA or Minimum/Difference payments; and

c) At least 36 months of said 120 months were earned during the 5 years immediately preceding election of Non-Active coverage.

A Member cannot become eligible for Non-Active retiree coverage as a Retired Member except under the conditions stated above.

(g) **Retired Self-Employed Members & Non-Pension Members**

1) A Self-Employed Member who is not eligible to receive a pension from the Carpenters' Pension Plan is nevertheless eligible for retiree coverage in this Plan in the Non-Active Classification provided the Self-Employed Member enrolls within 63 days after the date when all of the following conditions are first satisfied.

   a) The Self-Employed Member must attain age 55; and

   b) The Self-Employed Member must cease working; and

      1. The Self-Employed Member must have at least 120 months in any combination of:

         a. Months in which the Member performed bargaining unit work for an Employer signatory to a Collective Bargaining Agreement with the regional council but was not required to contribute to this Plan, or

         b. Months of coverage in the Hours-Based Eligibility Class earned by contributions to this Plan by a contributing Employer including months of coverage by COBRA or Minimum/Difference payments; and

      2. At least 36 months of said 120 months were earned during the 5 years immediately preceding election of Non-Active coverage.

2) A Non-Pension Member is an Active Member in the Hours-Based Eligibility Class other than a Self-Employed Member, who is not eligible to receive a pension from the Carpenters' Pension Plan. A Non-Pension Member is nevertheless eligible for retiree coverage in this Plan in the Non-Active Classification provided such Non-Pension Member enrolls within 63 days after the date when both of the following conditions are first satisfied:

   a) The Non-Pension Member must permanently cease all employment and inform the Plan in writing; and

   b) The Non-Pension Member must have at least 120 months in any combination of:

      1. Months in which the Member performed bargaining unit work for an Employer signatory to a Collective Bargaining Agreement with the regional council but was not required to contribute to this Plan, or

      2. Months of Active coverage in the Hours-Based Eligibility Class earned by contributions to this Plan by a contributing Employer including COBRA or Minimum/Difference payments; and

   c) At least 36 months of said 120 months must have been earned during the 5 years immediately preceding election of Non-Active coverage.

(h) **Disabled Members**

For purposes of eligibility for coverage in the Non-Active Classification, a "Disabled Member" is an individual who becomes Totally and Permanently Disabled when all the following conditions are met:

1) A Member first becomes eligible for Non-Active disabled coverage on the date the Member becomes Totally and Permanently Disabled unless, on that date, the Member is entitled to an additional period of Active Classification coverage on account of Credit Hours, or a prior

election of Minimum/Difference or COBRA coverage. In such cases, the Member first becomes eligible for Non-Active disabled coverage at the end of such extended period of Active Classification coverage; and

2) The Member elects such coverage within 63 days after first becoming eligible pursuant to subparagraph 1) above; and

3) The Member has at least 120 months, in any combination, of:

   a) Months in which the Member performed bargaining unit work for an Employer signatory to a Collective Bargaining Agreement with the regional council but was not required to contribute to this Plan;

   b) Months of coverage in the Hours-Based Eligibility Class earned by contributions to this Plan by a contributing Employer including months of coverage by COBRA or Minimum/Difference payments; and

4) At least 36 months of said 120 months were earned during the 5 years immediately preceding election of Non-Active coverage.

5) A Member cannot become eligible for Non-Active disability coverage as a Disabled Member except under the conditions stated above.

6) The Member must provide medical evidence of Total and Permanent Disability as soon as reasonably possible after it becomes available to the Member and, with respect to continuation of such Total and Permanent Disability, as often as requested by the Plan.

Non-Active disability coverage terminates if a Member ceases to satisfy the requirements necessary to establish Total and Permanent Disability.

(i) **Surviving Spouse**

For purposes of eligibility for coverage in the Non-Active Classification, a "surviving spouse" is a Member's Spouse who was covered as a Dependent at the time of the Member's death. A Surviving Spouse is eligible to maintain coverage in this Plan when all the following conditions are met:

1) The Surviving Spouse enrolls in such coverage within 63 days after the Member's death or, if later, the date on which the Surviving Spouse's coverage as the Member's Dependent ends if there is an extension of Active Classification coverage on account of the Member's Credit Hours or a prior election of Minimum/Difference coverage, and

2) The Member, prior to death, had at least 120 months, in any combination, of:

   a) Months in which the Member performed bargaining unit work for an Employer signatory to a Collective Bargaining Agreement with the regional council but not required to contribute to this Plan, or

   b) Months of Active coverage in the Hours-Based Eligibility Class earned by contributions to this Plan by a contributing Employer including coverage by COBRA or Minimum/Difference payments; and

3) At least 36 months of said 120 months were earned during the 5 years immediately preceding the Member's death. If the Member was entitled to a period of Active coverage extending beyond the date of the Member's death, the Surviving Spouse may maintain coverage for that period as the Member's Dependent.

4) The Surviving Spouse must not remarry.

At the time of enrollment, a Surviving Spouse may elect either single coverage or family coverage at the respective applicable Premiums. An election of family coverage provides coverage only for the Surviving Spouse and those persons, other than stepchildren, who were covered at the date of death as the Member's Dependent children. Surviving Spouse coverage terminates upon the remarriage of the Surviving Spouse.

Except as otherwise expressly provided, an individual covered as a Surviving Spouse in the Non-Active Classification is considered to be a Member for purposes of the Plan.

(j) **Working in the Non-Active Classification**

Members covered in the Non-Active Classification, other than as disabled, retired Self-Employed or Non-Pension Members, are not prohibited from receiving Employer contributions while working in covered employment in this Plan during Non-Active coverage. Members who receive health and welfare Credit Hours during Non-Active coverage will receive a refund or credit against their self-payment, up to the amount of the Employer contributions received by the Plan on account of hours worked and for reasons other than hours worked. The credit for hours worked in a month will not exceed the amount of the self-payment applicable for that benefit month.

In general, a Member who has begun Non-Active coverage may not reestablish Active coverage. However, any such Member is entitled to a one-time opportunity to reestablish coverage in the Active Classification under the following conditions:

1) The Member must notify the Plan Office in advance of the intent to have Credit Hours applied to reinstate Active eligibility, in which case Employer contributions for the Member will cease to be credited against self-payments and will begin to be credited toward initial Active eligibility;
2) The Member must satisfy the requirements for initial Hours-Based Eligibility while maintaining continuous Non-Active coverage; and
3) Only Credit Hours earned during Non-Active coverage as provided above will be applied to satisfy initial eligibility requirements.
4) A Member may move from Non-Active to Active coverage only once, except that a Member with Non-Active coverage by virtue of Total and Permanent Disability who ceases to be Totally and Permanently Disabled is not bound by this limitation.

(k) **Termination of Non-Active Eligibility**

A Non-Active Member's coverage will end on the earliest of the following dates:

1) In case of non-payment of the monthly contribution or payment received after the grace period, the end of the last month for which timely payment was received.
2) The date of the Member's death.
3) The date the Member falsifies any information in connection with coverage or a claim for benefits or commits any action with the intent to defraud the Plan.
4) The date a Member is found to have engaged in employment in the construction industry by an Employer who is not obligated to contribute to the Plan.
5) The date the Plan terminates.

In addition, a Non-Active Member's eligibility for all or most benefits in the Plan will end on the date when the Member is eligible for Medicare, as provided in Subsections 2.(a).1) and 2.(e) above.

D. Dependent Coverage

Except as otherwise provided in the Plan, eligibility of a Member's Dependents is determined by the same rules, regardless whether the Member has Active or Non-Active coverage. Coverage of Dependents of Members in the Active Classification is automatic unless there is a single option available and elected in the case of COBRA continuation coverage and Non-Bargained Office Employee coverage. Dependents of Members in the Non-Active Classification are covered only if the Member has elected family coverage at an increased Premium. A Medicare-eligible Dependent of a Non-Active Classification Member may be covered for limited Plan benefits by enrolling in our UHC coverage, at the applicable Premium, as described in Subsections 2(a)1) and 2(e) above. A Member's Dependents are the Member's Spouse and each Child of the Member under the age of 26 years, provided the additional conditions of eligibility of Spouses and children set forth below are met. Except for a Spouse and Child, no relative of a Member, or other person, is eligible as a Dependent regardless of financial support by the Member.

1. **Initial Dependent Coverage**

   For all Eligibility Classes, initial coverage of a Member's Dependents is derivative from the Member's eligibility. Coverage of a Dependent will begin when a Member's family coverage begins or when the Dependent is enrolled, whichever is later. If the Benefit Office receives a properly completed application for enrollment with all supporting documentation as requested by the Plan within 30 days after the Dependent becomes eligible, enrollment will be effective as of the eligibility date; otherwise, enrollment will be effective as of the date the Benefit Office receives such application. If a Dependent is temporarily enrolled without all required enrollment documentation and the request for supporting documentation is not fulfilled by the Member, the Dependent's coverage will be terminated prospectively. Failure to provide required documentation to the Plan is not a COBRA qualifying event and therefore, COBRA will not be offered. If, at a later date, all required enrollment documentation is received, coverage for such Dependents will be reinstated at the beginning of the month in which the required documentation is received by the Plan, but not retroactively.

2. **Spousal Eligibility**

   (a) **Spouse**

   For purposes of eligibility in this Plan, a Member's Spouse is the individual to whom the Member is married. The validity of a marriage shall be determined under the law of the state in which the marriage took place.

   An individual ceases to be a Member's Spouse upon divorce, annulment of marriage, legal separation, or death. Eligibility and coverage of a Dependent Spouse ends on the last day of the month in which a decree of divorce, annulment or legal separation is entered, or the day in which the Spouse's death occurs.

   (b) **Spousal Coverage Program for Qualified Working Spouses of Active Members**

   The Spouse of a Member in the Active Classification will not be eligible as a Dependent unless the Member and Spouse provide written verification about the employment status of the Spouse and, if employed, the Spouse's access to employer sponsored health care, whenever requested by the Plan.

   During any period when an Active Member's Spouse is employed and eligible to participate in an employer-sponsored Qualified Plan, the Spouse must enroll in the Qualified Plan offered through the Spouse's employer in order to be eligible for benefits in this Plan as a Dependent. When a Spouse has complied with this requirement, the plan of the Spouse's employer will be primary, and

this Plan will be secondary for benefits due to the Spouse under the Coordination of Benefit Rules of the Plan.

(c) **Qualified Plan; Enrollment Options**

For purposes of the spousal coverage rules, a "Qualified" employer-sponsored health plan, or Qualified Plan, is a plan that:

1) Is insured, or self-insured by the employer, and subject to regulation by state or federal agencies such as the US Department of Labor or Internal Revenue Service; and
2) Offers industry recognized standard benefits for Medically Necessary hospitalization, surgery and outpatient medical treatment and prescription coverage.

In cases where employees are given a choice of Plan designs by the employer, a working Spouse is required to enroll in at least single (Spouse only) coverage at the standard benefit level of a qualified plan (not high-deductible or limited coverage), as well as prescription drug coverage if offered. A Spouse is not required to elect dental or vision benefits, or family coverage.

However, if the Trustees determine that it would be in the interest of this Plan to do so, they may require a working Spouse to enroll any Dependent children in the Spouse's health plan, provided that this Plan pays the premium that the Spouse would be otherwise required to pay to do so. Failure of the working Spouse to enroll any such Dependent children in the Qualified Plan per the Trustees' request shall render the Spouse ineligible for coverage under the Plan.

(d) **Exceptions**

A working Spouse is not required to enroll in an employer-sponsored plan in order to maintain eligibility in this Plan, if any of the following situations apply:

1) If the Spouse is Self-Employed and has no other employees or does not offer health coverage.
2) If the Spouse is not employed full-time within the meaning of Section 4980H of the Internal Revenue Code (generally, less than 30 hours per week or on average less than 130 hours per month).
3) If the Spouse's employer does not contribute toward the cost of the Spouse's health coverage, and thereby, requires the Spouse to pay 100% of the cost.
4) If the Spouse is already enrolled in a Qualified Plan other than the Spouse's employer-sponsored health plan and that Plan is primary to this Plan.
5) If the Trustees determine that due to unusual and unforeseen circumstances, enrollment by the Spouse would impose extreme hardship. So long as the Spouse's employer also contributes to the cost of coverage, enrollment will not ordinarily be deemed an extreme hardship.

(e) **Facilitation of Enrollment**

The Benefit Plan Administrator is authorized to terminate eligibility of a Dependent Spouse for benefits from this Plan, if necessary, to enable the Spouse to enroll in the plan of the Spouse's employer, and to reinstate eligibility in this Plan after the Spouse has enrolled in the plan of the Spouse's employer.

A working Spouse will not lose eligibility in this Plan solely on account of a mandatory waiting period following application for enrollment in the employer's plan, provided the Spouse's application was made in time to prevent loss of eligibility.

(f) **Verification of Enrollment**

The Trustees may require written verification from a working Spouse's employer that any of the requirements of this Plan for maintaining working Spouse eligibility have been satisfied. For example, such verification may be requested concerning the type of health coverage offered by the employer, the employer's contribution to the cost of coverage, the date and type of coverage elected by the Spouse, the Spouse's hours of employment, or other relevant facts.

(g) **Failure to Enroll**

If an Active Member's working Spouse fails to enroll in an employer-sponsored health plan when required, or if the Member or Spouse or Spouse's employer fails to provide required information requested by the Plan, the Spouse's eligibility for benefits in this Plan will terminate. Failure to enroll or comply with required information requested by the Plan is not a COBRA qualifying event. If the Spouse thereafter enrolls in the Spouse's employer-sponsored health plan, or if the required information is provided, the Spouse's eligibility in this Plan will be reinstated at the beginning of the month in which the required enrollment or information is completed, but not retroactively.

For purposes of the spousal coverage rules, "required information" includes a complete response from a Member and Spouse to an information request from the Plan, as well as written verification from the Spouse's employer after request from the Plan.

3. **Dependent Child Eligibility**

(a) **Child**

For purposes of eligibility for benefits in this Plan, a Member's "child" is any of the following, provided in each case that the child is a "Child" or "Dependent" of the Member within the meaning of section 105(b) of the Internal Revenue Code:

1) A natural child (a child by relation or procreation); or
2) A child adopted by judicial decree; or
3) A child legally placed for adoption in the Member's home; or
4) A child for whom the Plan is required to provide coverage pursuant to a Qualified Medical Child Support Order (QMCSO); or
5) The Member's step-child, provided the child's natural parent is the Member's Spouse.

(b) **Eligible Child**

A Member's Child is eligible for Dependent coverage until the last day of the calendar month in which Child's 26th birthday occurs.

(c) **Disabled Child**

A Member's Child may remain eligible for Dependent coverage on and after the Child's 26th birthday if, and so long as, the Child is Totally and Permanently Disabled and the Member is entitled to and does claim a deduction for the Child on the Member's federal income tax return.

A Member's Child is not eligible for Dependent coverage after age 26 unless, no later than 63 days after the Child's 26th birthday, and as often thereafter as requested by the Plan, the Member presents proof that the foregoing conditions existed on that birthday and continuously thereafter.

4. **Opting out of Dependent Coverage**

Any individual eligible for Dependent coverage may opt out of such coverage by signed written notice to the Trustees, specifying the date on which such coverage will terminate. Any individual who has voluntarily terminated Dependent coverage may reinstate such coverage by written notice to the

Trustees, provided the individual is eligible for Dependent coverage at the time of reinstatement. The parent of a Child under the age of 18 may request to opt out of coverage on behalf of the minor Child. A Dependent Child age 18 or older or a Spouse must request to opt out of the Plan individually.

5. **Termination of Dependent Eligibility**

Except as provided for a Dependent who has elected COBRA, eligibility of a Member's Dependent will automatically end on the last day of the month in which the earliest of the following dates occurs:

The date the Member's eligibility ends, except as follows:

(a) Eligibility of Dependents of a Member in the Non-Active Classification will not terminate solely because the Member becomes Entitled to Medicare, if and so long as the Member is enrolled in the UHC Medicare Advantage Program.

(b) In the event of the death of a Member while covered in the Hours-Based Eligibility Class, the Member's Dependents will remain covered until the end of the third month after the month in which the death occurred, or if later, until the end of the eligibility period earned by the Member's Credit Hours as of the date of death.

(c) The date the individual no longer qualifies as an eligible Dependent under the terms of the Plan.

(d) The date a Dependent is eligible for Medicare that is primary to the Plan, but is not enrolled in both Medicare Part A and B. An Active Classification Member's Medicare coverage is primary to this Plan if the Dependent has had 30 months of secondary Medicare coverage on account of End-Stage Renal Disease and the Medicare is now primary to this Plan, except if the Member's eligibility is based on COBRA continuation coverage.

(e) The date the Member fails to provide supporting enrollment documentation as requested by the Plan.

(f) The date the Dependent falsifies any information in connection with coverage or a claim for benefits or commits any action with the intent to defraud the Plan.

(g) The date the Plan terminates.

E. COBRA Continuation Coverage

The Plan provisions in this Subsection E summarize COBRA rules likely to apply to this Plan and its Covered Persons, but do not describe all provisions of the law. The Plan will be administered in compliance with the requirements of the Code and ERISA relating to COBRA continuation coverage. The law shall take precedence in any case where the requirements of the law are more favorable to Covered Persons than the Plan.

Every Qualified beneficiary who would otherwise lose coverage on account of the Qualifying Event is eligible to elect COBRA continuation coverage. An Active Member who maintains coverage after a Qualifying Event by electing COBRA in lieu of Minimum/Difference payments may not elect Minimum/Difference payments to maintain Active coverage at the termination of the COBRA coverage, unless and until the Member reestablishes eligibility as provided in the Plan. Conversely, an Active Member who maintains coverage after a Qualifying Event by electing Minimum/Difference payments in lieu of COBRA may not elect COBRA to maintain Active coverage at the termination of the period of Minimum/Difference payments, unless the Member reestablishes eligibility as provided in the Plan, or unless a second Qualifying Event occurs before such termination.

Unlike most other coverage under the Plan, each individual Member and Dependent who is a Qualified Beneficiary is entitled to make an individual COBRA election upon the occurrence of a Qualifying Event. A

Qualified Beneficiary who elects COBRA must pay the COBRA Premiums established by the Trustees in order to begin and maintain COBRA continuation coverage.

1. **COBRA Qualifying Events**

   Any of the following is a Qualifying Event if it would cause a Qualified Beneficiary to lose coverage in the Plan:

   (a) A reduction in a Member's hours of employment; or

   (b) Termination of a Member's employment for reasons other than gross misconduct; or

   (c) Bankruptcy of a Retired Member's former Employer; or

   (d) Death of a Member; or

   (e) Divorce or legal separation of a Member and Spouse; or

   (f) A Member becoming Entitled to Medicare; or

   (g) A Child attaining age 26, or otherwise ceasing to qualify as a Member's Dependent.

2. **Qualified Beneficiary**

   A Qualified Beneficiary is a Covered Person who is eligible for benefits in the Plan as stated below:

   (a) A Member eligible in the Active Classification other than coverage maintained by Minimum/Difference or Non-Active Classification payments; or

   (b) A Dependent eligible in the Active or Non-Active Classification; or

   (c) A child born to or placed for adoption with Member during a period of COBRA coverage.

   A Qualified Beneficiary described in Section 2(a) and 2(b) above must be (i) covered by such coverage on the day before occurrence of a Qualifying Event with respect to such Covered Person, and (ii) subject to loss of such coverage on account of the Qualifying Event. A Member can be a Qualified Beneficiary only with respect to termination or reduction in hours of the Member's employment, bankruptcy of the Member's Employer, or the Member becoming Entitled to Medicare.

   A Qualified Beneficiary described in Section 2(c) above has an independent right to elect COBRA coverage for the balance of the original COBRA period irrespective whether the Member's continuation coverage ends before the end of the maximum period. Although a child born to or placed for adoption with a Member during a period of COBRA continuation coverage is a Qualified Beneficiary, a child born to or placed for adoption with a Qualified Beneficiary other than the Member after a qualifying event, or a person who becomes the spouse of a Qualified Beneficiary (regardless of whether the Qualified Beneficiary is the Member) after a qualifying event is not a Qualified Beneficiary" and does not have an independent right to elect COBRA coverage.

3. **COBRA Benefits**

   The benefits provided under COBRA continuation coverage are the same medical, prescription drug, dental and vision benefits to which the electing Qualified Beneficiary would have been entitled during the continuation period if the Qualifying Event had not occurred. An electing Qualified Beneficiary has the same rights to add Dependents or change coverage as Active Members. Incidental Plan benefits (Life and Accidental Death and Dismemberment insurance and Short-Term Disability benefits) are not provided under COBRA.

4. **Required Notices, Election and Payments for COBRA Continuation Coverage**

(a) **Notices the Qualified Beneficiary Must Give to the Plan**

1) **Certain Original Qualifying Events**

A Qualified Beneficiary who would lose coverage because of a Member's divorce or legal separation, or because of a Member's child ceasing to qualify as a Dependent, will lose the right to elect COBRA on account of such Qualifying Event unless the Plan receives notice of the Qualifying Event within 60 days after the latest of:

a) The date of such event; or

b) The date coverage would terminate because of that event.

2) **Second Qualifying Event**

If a second Qualifying Event described in paragraph 1) above occurs with respect to a Qualified Beneficiary who is covered under COBRA, that Qualified Beneficiary will lose the COBRA rights associated with the second event unless the Plan receives notice of the second Qualifying Event within 60 days after the latest of:

a) The date of the second qualifying event; or

b) The date coverage would otherwise terminate.

3) **Social Security Disability Determinations**

A Qualified Beneficiary who has elected COBRA, and who thereafter is determined for purposes of Social Security Disability to be disabled some time during the first 60 days of COBRA coverage, regardless whether the disability started prior to or during that period, will lose the right to a disability extension of COBRA coverage unless the Plan receives notice of the determination within the first 18 months of COBRA coverage and within 60 days after the date the determination is issued or the date COBRA coverage began.

If a Qualified Beneficiary's disability under Social Security ends, the Qualified Beneficiary must notify the Plan no later than 30 days after the date the determination is issued.

(b) **Notices the Plan Must Give to Qualified Beneficiaries**

The Plan will notify Qualified Beneficiaries of their COBRA rights within 30 days after the Plan receives notice of the occurrence of a Qualifying Event.

5. **Election of COBRA Continuation Coverage**

To become entitled to COBRA continuation coverage, a Qualified Beneficiary must notify the Plan of election of COBRA within 60 days after the later of:

(a) The date the Qualified Beneficiary would lose coverage because of the Qualifying Event, or

(b) The date the Qualified Beneficiary receives the Plan's notice of COBRA rights after the Qualifying Event.

A Qualified Beneficiary elects COBRA continuation coverage by returning a completed COBRA election form to the Plan within the 60-day period. A Qualified Beneficiary may not make a COBRA election after expiration of the time specified above.

Unless otherwise specified in an election, a COBRA election made by a Member or Dependent Spouse is an election on behalf of all Qualified Beneficiaries.

6. **Payment for COBRA Coverage**

The monthly Premium for COBRA continuation coverage is set by the Trustees from time to time. The initial payment is due within 45 days after the date the COBRA election is made. The first payment

must include payment for all months between the termination of regular coverage and the date of the election. Subsequent payments are due on the first day of each month and will not be accepted more than 30 days after the due date. COBRA coverage will terminate permanently if any payment is not made within the allowed time periods.

7. **Coverage during Election Period and Payment Periods**
   The Plan will not pay claims after regular coverage ends on account of a Qualifying Event, until a Qualified Beneficiary both elects COBRA and makes a timely initial payment. Similarly, if a Qualified Beneficiary does not make a monthly payment by the due date, benefits will be suspended until the monthly payment is received before the end of the grace period.

8. **Duration of COBRA Continuation Coverage**

   (a) **Termination or Reduction of Hours of Employment**
   If the Qualifying Event is termination or reduction in hours of employment, the maximum period of COBRA continuation coverage ends 18 months after the date of the Qualifying Event unless extended for one of the following reasons:

   1) **Social Security Disability**
   If, prior to the end of the 18-month coverage period, any Qualified Beneficiary who elected COBRA is determined by Social Security to be disabled at some time during the first 60 days of COBRA coverage, regardless of whether the disability started prior to or during that period, the maximum COBRA continuation period is extended for an additional 11 months. The disabled person, and all other qualified beneficiaries who have COBRA coverage by virtue of the same Qualifying Event, may purchase coverage for up to a total of 29 months from the date of the original qualifying event. The Premium for coverage of the disabled person during the 11-month extension is 150% of the normal COBRA Premium as published by the Board of Trustees.

   2) **Medicare Entitlement**
   If a Member was Entitled to Medicare at the time of the Qualifying Event, the Member's COBRA maximum coverage period of 18 months does not change, but the maximum COBRA coverage period for the Member's Dependents will not end sooner than 36 months after the date the Member became eligible for Medicare.

   3) **Second Qualifying Event**
   If a second Qualifying Event occurs during the 18-month or 29-month coverage period in which a Qualified Beneficiary is covered by COBRA, and timely notice is given to the Plan, the maximum COBRA coverage period will be extended to 36 months from the date of the original Qualifying Event for the Qualified Beneficiaries affected by the second Qualifying Event. The extension is in lieu of a new period of coverage that would otherwise start with the second Qualifying Event.

   If a second Qualifying Event occurs during a period in which a Qualified Beneficiary is covered by Minimum/Difference or Non-Active Classification coverage, and timely notice is given to the Plan, the Qualified Beneficiary will be entitled to 36 months from the date of the second Qualifying Event as if there were no previous Qualifying Event.

   (b) **Other Qualifying Events**
   For all Qualifying Events other than the termination or reduction in hours of employment, the maximum COBRA continuation period is 36 months from the date of the Qualifying Event.

9. **Termination of COBRA Continuation Coverage**

All rights to COBRA continuation coverage permanently end on the earliest of the following occurrences:

(a) The expiration of the applicable maximum COBRA continuation period.

(b) The Qualified Beneficiary's failure to make a payment before the end of the applicable grace period.

(c) The date a Member is found to have engaged in employment in the construction industry by an Employer who is not obligated to contribute to the Plan.

(d) The date on which a Qualified Beneficiary who elected COBRA first becomes covered under Medicare or under another group health plan, except to the extent that the other group plan limits coverage of the individual due to the individual's pre-existing condition.

(e) For COBRA coverage that is extended due to disability, the first day of the first month that begins more than 30 days after the date that the disabled Qualified Beneficiary is finally determined by the Social Security Administration to no longer be disabled.

F. American Rescue Plan Act of 2021

The provisions contained this Subsection F incorporate and apply the provisions of the American Rescue Plan Act of 2021 (the "ARP") to the Plan. The Plan shall be administered in compliance with the ARP relating to COBRA continuation coverage. If any provision of this Subsection F or the Plan is contrary to the ARP, such provisions shall be interpreted and applied in compliance with the ARP, as it may be amended from time to time.

1. **COBRA Continuation Coverage Premium Assistance under the ARP**

The Plan will treat Assistance Eligible Individuals as having paid the full amount of the COBRA continuation coverage Premium for the periods of coverage during which the individual qualifies as an Assistance Eligible Individual. In accordance with Section 9501 of the ARP, the Premium reduction shall apply to an Assistance Eligible Individual as of the first period of coverage beginning on or after April 1, 2021, and ending on September 30, 2021; provided, such period shall be extended to the extent required pursuant to any subsequent amendment of Section 9501 of the ARP (the "Premium Reduction Period"). The Premium Reduction Period shall end for any month of COBRA continuation coverage beginning on or after the earlier of the following dates:

(a) the first date that the Assistance Eligible Individual is eligible for coverage under any other group health plan (other than coverage consisting of only excepted benefits (as defined in Section 9832(c) of the Code, Section 733(c) of ERISA, and Section 2791(c) of the Public Health Service Act), coverage under a flexible spending arrangement (as defined in Section 106(c)(2) of the Code, or coverage under a qualified small employer health reimbursement arrangement (as defined in Section 9831(d)(2) of the Code));

(b) the first date that the Assistance Eligible Individual is eligible for benefits under the Medicare program under title XVIII of the Social Security Act; or

(c) the date on which the Assistance Eligible Individual's maximum COBRA continuation coverage period ends.

An Assistance Eligible Individual must notify the Plan immediately upon becoming eligible for other group health plan coverage or Medicare.

For purposes of the Plan, "Assistance Eligible Individual" means, with respect to a period of COBRA continuation coverage during the Premium Reduction Period, a Qualified Beneficiary who a) is eligible for COBRA continuation coverage under the Plan by reason of a qualifying event that is a reduction in hours

or an involuntary termination of employment and b) elects COBRA continuation coverage in accordance with the Plan's procedures and applicable law, including the ARP.

2. **Extended Election Opportunity under the ARP**

An individual who does not have a COBRA continuation coverage election in effect on April 1, 2021, but who would be an Assistance Eligible Individual if such an election was in effect, or an individual who elected COBRA continuation coverage but discontinued such coverage before April 1, 2021, shall be provided an extended COBRA continuation coverage election period in accordance with Section 9501 of the ARP. The Plan will provide individuals who qualify for the extended election period with a notice of the extended election period, and such individuals shall have 60 days after receipt of the notice to elect COBRA continuation coverage. COBRA continuation coverage elected pursuant to the extended election opportunity may be elected effective for coverage beginning April 1, 2021, or from an earlier Qualifying Event if such individual is eligible to elect COBRA continuation coverage from such earlier date, including under the extended COBRA continuation coverage election period provided under the Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak issued by the Departments of Labor and the Treasury, EBSA Notice 2021-01, or such other guidance of a governmental agency which applies to the Plan.

3. **Minimum/Difference Self-Payments and the ARP**

The provisions of this Subsection I.F.3. modify the Minimum/Difference self-payment provisions of Subsection I.C.f.3)b. to the extent such provisions are contrary hereto.

A Member whose Qualifying Event occurred on or after March 1, 2020, and who would otherwise qualify as an Assistance Eligible Individual but for the Member's waiver of COBRA continuation coverage in connection with his or her election of Minimum/Difference payments in accordance with the Plan shall be eligible to revoke his or her waiver of COBRA continuation coverage and elect COBRA continuation coverage effective April 1, 2021, in accordance with the provisions of this Subsection I.F., and, upon such election of COBRA continuation coverage, shall have his or her Minimum/Difference coverage period tolled during the period during which the individual qualifies as an Assistance Eligible Individual. A Member who elects and continuously maintains COBRA continuation coverage pursuant to this paragraph for the duration of the Premium Reduction Period and is eligible for Minimum/Difference coverage upon entering into the Premium Reduction Period shall be eligible to elect or resume Minimum/Difference payments effective on the earlier of the date the Member no longer qualifies as an Assistance Eligible Individual and October 1, 2021 (or such later date if the Premium Reduction Period under the ARP is extended), for the remainder of his or her otherwise applicable Minimum/Difference coverage period described in Subsection I.C.f.3)b. The election to continue Minimum/Difference self-payments must be made within 30 days of the end of the Premium Reduction Period and payment of the Minimum/Difference premium must be made within 15 days of the Member's election.[1]

An individual who would qualify as an Assistance Eligible Individual and who waives otherwise available Minimum/Difference self-payments under the Plan by electing COBRA continuation coverage during the Premium Reduction Period shall have his or her Minimum/Difference coverage period tolled during the period he or she qualifies as an Assistance Eligible Individual and shall be permitted to elect Minimum/Difference self-payments in accordance with the Plan for the remainder of his or her otherwise applicable Minimum/Difference coverage period described in Subsection I.C.f.3)b. upon the expiration of the Member's qualification as an Assistance Eligible Individual.

Section II

Medical Benefit

A. Levels of Medical Benefit

1. Schedule of Benefits

The Plan's Medical Benefit provides benefits for a wide range of health care services and supplies used to diagnose and treat Injury or Sickness, or to maintain wellness. This Plan of Benefits is known as the Platinum Plan. The Medical Benefit does not cover prescription drugs, vision care or dental care, each of which is covered by a separate benefit and Section. However, some of the provisions of this Section II apply by their terms to Plan benefits in addition to the Medical Benefit.

The Platinum Plan Schedule of medical benefits is set forth in Appendix A. The Schedule provides generally 90% medical Coinsurance.

2. Medical Networks

The Plan enters into contracts with medical Network Sponsors allowing Covered Persons to have access to Networks of Hospitals, Physicians and other health care Providers. In general, the Plan's benefits will be higher for an In-Network Provider than for a Non-Network Provider. Covered Persons are free to choose to obtain most medical services and supplies from either an In-Network Provider or a Non-Network Provider. However, certain services and supplies are covered only if obtained from an In-Network Provider, as noted in this Subsection C.1 below.

If an In-Network Provider is chosen, the Plan's benefits covered are higher than if a Non-Network Provider is chosen. In addition, In-Network Providers may not charge more than the amount contractually agreed with the Network Sponsor and may not require Covered Persons to pay more than the Copay, or the deductible and Coinsurance share, based on that amount.

If a Non-Network Provider is chosen, the Plan's benefits covered are lower than for an In-Network Provider and are subject in any event to the Plan's reasonable and customary limitation. A Non-Network Provider is not limited in the amount it can charge a Covered Person after receiving the Plan's benefits.

The Plan's Networks at the date of this restated Plan Document, for purposes of medical care under the Platinum Schedule, are as follows:

(a) **Carpenters Wellness Center**

Located at 1403 Hampton Ave in St. Louis, MO, Carpenters Wellness Center is available to all covered Members and Dependents ages 2 and older with no out-of-pocket cost for most services. Services include: primary care services, annual school and sports physicals, acute care and sick care visits, chiropractic care, dental care, holistic pain management, lab services, massage therapy, mental health and substance abuse counseling, patient education, pharmacy, physical therapy, preventive care, vaccinations and immunizations, vision care services, wellness training and x-ray. Updated services and hours of operation are listed on the Plan's website: https://www.carpdc.org/WellnessCenter.

1) Dental care is available to non-Medicare Members and Dependents covered by Non-Active retiree coverage only if optional dental coverage is elected.

2) Members and Dependents covered under the United Healthcare Advantage Plan are eligible for pharmacy and vision care services as well as dental care if optional dental coverage is elected.

(b) **General Medical Networks**

The Open Access Plus (OAP) Network, offered through Cigna Health and Life Insurance Company (Cigna) is the Plan's General Medical Network. In-Network benefits apply to all Providers in this Network, except for organ transplants, and treatment under the Member Assistance Program (Mercy MAP).

(c) **Transplant and Related Therapies Networks**

The Plan's Transplant Network is a designated group of Providers within the Cigna LIFESOURCE Transplant Network Services and supplies for organ transplants must be obtained in the Transplant Network to be covered. Advanced cellular therapy, including but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, must be performed at a Cigna LIFESOURCE Transplant Network® facility with a Cigna approved stem cell transplant program.

(d) **Member Assistance Program**

The Member Assistance Program (MAP) is part of Mercy's Mental Health and Substance Abuse Network with certain providers contracted for the MAP services.

The Plan maintains updated information about Networks and In-Network Providers at the Plan Office and on the Plan's website, www.carpdc.org/BenefitServices.

B. Determination of Benefit Amounts

1. **Allowable Amount**

Upon receiving a claim, and after confirming it is an Allowable Claim because the claimant is eligible for benefits, the service or supply is covered by the Plan, and any required pre-authorization was granted, the Plan determines the Allowable Amount of the claim. The Allowable Amount is the maximum benefit that the Plan would pay on a claim if the Coinsurance rate were 100%, and if no deductible or Copay were applicable. For a charge from an In-Network Provider, the Allowable Amount is the uniform charge the Provider has agreed to accept as a member of the Network. For a charge from a Non-Network Provider, the Allowable Amount is the lesser of the amount charged, or the reasonable and customary amount. In all cases, the Allowable Amount is reduced as necessary to conform to any other specific limitations set forth in the Plan.

2. **Reasonable and Customary Limit**

For coverage under all Benefit Schedules, the reasonable and customary amount for services and supplies covered by Medicare is equal to 100% of the Medicare approved amount. For services supplies not covered by Medicare, the Trustees have discretion to determine the method by which the reasonable and customary amount will be established and may rely upon data furnished from sources deemed appropriate by the Trustees. In case of a charge from a Non-Network Provider, no Plan benefit will be paid based on an Allowable Amount in excess of the reasonable and customary amount.

3. **Deductibles**

The Plan's deductible is an aggregate annual amount that must be paid by a Covered Person toward Allowable Claims incurred in a calendar year before any Plan benefits become payable for claims incurred in that year. The Individual Deductible is the deductible amount that must be paid on behalf of any individual Covered Person before Plan benefits will be paid to or for that person, unless and

until the Family Deductible is satisfied. The Family Deductible is the deductible amount that, once paid for any combination of a Member and the Member's Dependents, satisfies the Individual Deductible for the Member and all of the Member's Dependents for claims incurred during the remainder of the calendar year. The deductible does not apply to a benefit for which a Copayment is required.

4. **Copayments**
   A Copayment is a fixed dollar amount that must be paid by a Covered Person towards an Allowable Claim for a particular service or supply, as set forth in the applicable Schedule of Benefits. Copayments for a service or supply are in lieu of any Coinsurance for that service or supply and are payable whether or not the Covered Person's deductible has been met. Copayments are no longer required if an Out-of-Pocket Maximum applicable to the patient claim has been satisfied.

5. **Coinsurance**
   After any applicable deductible is satisfied, Coinsurance is the percentage of the remaining Allowable Amount that will be paid by the Plan for a particular service or supply, as set forth in the applicable Schedule of Benefits. The balance of the claim is payable by the Covered Person who incurred the claim. If an Out-of-Pocket Maximum applicable to the patient and claim has been satisfied, the Coinsurance rate becomes 100%.

6. **Out-of-Pocket Maximum**
   The individual Out-of-Pocket Maximum for medical benefits is an annual amount that, when satisfied, relieves a Covered Person from further deductibles and Copayments, and changes the Coinsurance rate to 100%, for all further In-Network Allowable Claims incurred in the same year. The individual Out-of-Pocket Maximum is satisfied when the sum of all deductibles, Copayments, and charges in excess of the Plan's Coinsurance share paid by a Covered Person on account of In-Network Allowable Claims incurred in a calendar year equals the Individual Out-of-Pocket Maximum amount stated in the applicable Schedule of Benefits. When the combined amount of such payments made in a calendar year for any combination of a Member and the Member's Dependents equals the Family Out-of-Pocket Maximum, the Individual Out-of-Pocket Maximum is satisfied for the Member and all of the Member's Dependents for In-Network claims incurred during the remainder of the same calendar year. Amounts paid by a Covered Person on a Non-Network claim do not count toward satisfying the Out-of-Pocket Maximum. Regardless of satisfying the Out-of-Pocket Maximums, a Covered Person is responsible for the following:
   (a) Charges for services and supplies not covered by the Plan.
   (b) Charges from a Non-Network Provider in excess of the Plan's Allowable Amount.
   (c) Charges from a Non-Network Provider for which no Plan benefits are paid because of failure to obtain required Prior Authorizations.
   (d) Charges exceeding Plan benefits for services and supplies within the Prescription Drug Benefit, the Dental Benefit, or the Vision Benefit.

7. **Specific Plan Limits**
   The Plan limits the number of days, visits, or other quantities of certain specific kinds of services and supplies for which benefits will be paid. Quantities exceeding these limits are not services and supplies covered by the Plan. The Plan also limits the dollar amount of benefits paid for certain specific covered services and supplies. Irrespective of all other factors, the benefits actually paid by the Plan for such services and supplies will not exceed the limit amount. These specific limitations are set forth in the Schedules of Benefits and Subsection C below.

8. **Benefits Payable**

The benefits payable by the Plan for an Allowable Claim is the Allowable Amount, less the Copayment if any Copayment is required, less the unsatisfied amount of any applicable deductible, multiplied by the applicable Coinsurance percentage, subject to any specific limitations. If an applicable Out-of-Pocket Maximum is satisfied, the benefit payable is the Allowable Amount, subject to any specific limitations.

For covered services and supplies listed and designated as Preventive services and supplies in Subsection C.2 below, the benefit payable by the Plan is the Allowable Amount.

C. Covered Services and Supplies

No benefits are provided for services and supplies not covered by the Plan. Except as otherwise specifically provided, the Plan covers only those services and supplies that are:

- Listed in these Subsections C.1 and C.2 as covered; and
- Medically Necessary, unless otherwise stated in these Subsections C.1 and C.2; and
- Performed or ordered and supervised by a Physician, or other medical professional if noted; and
- Not excluded under the general exclusions and limitations set forth in this Subsection C,3 below.

In addition to these basic conditions, certain covered services and supplies are also subject to specific limitations set forth in these Subsections C.1 and C.3, and to the Prior Authorization requirements described in this Subsection D below.

1. **Listed Non-Preventive Services and Supplies**

Inclusion of a service or supply in Appendix B means the service or supply is eligible for coverage, with stated limitations, but does not guarantee whether, or to what extent, benefits are payable.

2. **Listed Preventive Services and Supplies**

The Preventive services and supplies listed in Appendix C are eligible for coverage regardless of Medical Necessity unless otherwise stated. Except as noted, benefits for Preventive services and supplies listed in Appendix C, if obtained from an In-Network Provider, are payable without cost-sharing; i.e., payable at a 100% Coinsurance rate without any deductible or Copayment. A service or supply listed in Appendix C and obtained from a Non-Network Provider is subject to the reasonable and customary limitation, and deductibles, Copays and Coinsurance in accordance with the applicable Benefit Schedule. Inclusion of a service or supply in Appendix C, alone, does not guarantee benefits are payable.

The Plan's Preventive services and supplies listed in Appendix C are intended to conform to all the following:

- Recommendations of the United States Preventive Services Task Force with rating of A or B,
- Immunizations with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control, and
- For women, infants, children and adolescents, guidelines supported by the Health Resources and Services Administration, all of which are referred to herein jointly as the "Preventive Recommendations."

The Preventive Recommendations are incorporated herein by reference, and the provisions of this Subsection C,2 shall be interpreted accordingly. Appendix C shall be automatically amended as necessary from time to time to conform to future changes in the Preventive Recommendations.

3. **General Medical Exclusions and Limitations**
   Irrespective of all other provisions, no medical benefits will be paid for or in connection with services listed in Appendix D.

D. Prior Authorization Requirements

In most cases, a service or supply must be Medically Necessary as a condition of receiving benefits. The Plan specifies certain services and supplies for which Prior Authorization is required as a condition of receiving such benefits. Prior Authorization, also called utilization management, is a determination made by the Plan in advance, as to whether a proposed service or supply is Medically Necessary. The Plan ordinarily bases this determination on advice received from medical professionals, who may be furnished by Network Sponsors or may be independent medical experts retained by the Plan.

Prior Authorization only confirms a proposed service or supply is considered Medically Necessary for purposes of qualifying for Plan benefits. Prior Authorization alone does not guarantee either coverage, or availability of benefits. Prior Authorization is not intended, and should not be used, as medical advice about the appropriate or advisable course of medical treatment, which remains the exclusive responsibility of the Covered Person and attending Physician.

1. **Services and Supplies which Require Prior Authorization as a Condition of Benefits.**
   The following is a summary list of medical services and supplies for which Prior Authorization is required in some or all cases as a condition of payment of any benefit. This requirement is stated with additional detail in Appendix B and Appendix C. This list is subject to additions and changes. For a complete list of required Prior Authorizations, refer to www.carpdc.org/BenefitServices.

   (a) Abortion
   (b) Advanced Radiology Services
   (c) Ambulance service by air and water, or transfers between facilities
   (d) Breast pumps, Hospital grade
   (e) Brachytherapy
   (f) Chemotherapy and Radiation Therapy
   (g) Clinical Trials
   (h) Cosmetic, Plastic and Related Reconstructive Surgery
   (i) Dental Services (when covered under Medical Benefit)
   (j) Dialysis
   (k) Durable Medical Equipment
   (l) Genetic Testing and Counseling
   (m) Global Obstetrical Care
   (n) Home Health Care Services
   (o) Hyperbaric treatment
   (p) Inpatient Hospital Care, except maternity admission to a Hospital not exceeding 48 hours following a vaginal delivery or 96 hours following a Cesarean section
   (q) Inpatient, Residential, Intensive Outpatient and Partial Hospitalization Mental and Nervous Disorders and Substance Abuse
   (r) Mastectomy
   (s) Medical Complications

(t) Newborn Inpatient Care After Discharge of Mother

(u) Orthopedic devices over $500

(v) Outpatient Diagnostic Tests and Therapeutic Treatments

(w) Outpatient Surgery

(x) Pain Management Injections

(y) PKU or other Amino and Organic Acid Inherited Disease Formula and Food

(z) Proton Beam Therapy

(aa) Prosthetic Devices and Braces over $10,000, and refitting or replacements

(bb) CT scans, MRIs, MRAs, PET scans

(cc) Sclerotherapy

(dd) Sleep Studies

(ee) Skilled Nursing Facilities

(ff) TMJ treatment – surgical or non-surgical

(gg) Transplants and Related Therapies, including stem cell and bone marrow transplants and (CAR-T) cellular therapy

2. **Prior Authorization Procedures**

The Plan contracts for its Network Sponsors to furnish Prior Authorization advice concerning a proposed service or supply, regardless whether the proposed Provider is an In-Network or a Non-Network Provider. A Prior Authorization request for a proposed service or supply must therefore be directed to the Network Sponsor of the Network whose Providers would be In-Network Providers for that service or supply. In a large majority of cases, this will be the Plan's General Medical Network, but could instead be the Mental Health and Substance Abuse Network, the Transplant Network, or the Cigna LifeSOURCE Transplant Network®.

If a Covered Person seeks care from an In-Network Provider, the Provider is responsible for obtaining any required Prior Authorization. The Covered Person will not suffer any loss of benefits if the In-Network Provider fails to request a Prior Authorization.

If a Covered Person seeks care from a Non-Network Provider, the Covered Person is responsible for ensuring any required Prior Authorization has been obtained. In such case, the Covered Person or attending Physician must request and receive Prior Authorization prior to providing a proposed, non-emergent service or supply by calling the appropriate Network Sponsor and must furnish all requested information. In case of an Emergency admission to a Hospital, or Emergency treatment of mental or nervous disorders or substance abuse, the call will be timely if made within the next business day. Prior Authorization is satisfied only if certified by the appropriate Network Sponsor.

Prior Authorization granted for a Hospitalization will include an approved level of care or department of the facility, and initial length of stay. After a patient's admission to the Hospital, the attending Physician may request one or more extensions of the length of stay, with information supporting the request. Inpatient Hospital care is not covered by the Plan after the expiration of the length of stay, or for a higher level of care, than that for which Prior Authorization was granted.

The Plan, in its discretion, may act upon Prior Authorization advice received from the appropriate Network Sponsor, or may request a second opinion from an independent professional source.

3. **Consequences of Failure to Obtain Required Prior Authorization**
   The Plan will pay no benefits for a service or supply if Prior Authorization is denied.

   The Plan will deny a claim for benefits if a timely request was not made and granted for Prior Authorization of a service or supply obtained from a Non-Network Provider, except under the circumstances that would make obtaining Prior Authorization impossible or could seriously jeopardize the life or health of the Claimant. If, within 60 days following such denial, the Covered Person provides evidence satisfactory to the Trustees of good cause for the failure to make a timely request, the Plan will conduct a retrospective review and determination whether the service or supply in question was Medically Necessary. The claim denial will stand as the Plan's initial claim determination in the absence of such good cause shown, or if the service or supply is determined on retrospective review not to have been Medically Necessary. If the service or supply is determined on retrospective review to have been Medically Necessary, the failure to make a timely request will be waived.

E. Medical Care Management

The Plan maintains programs designed to provide education, support and coordination services to Members and Dependents. Participation in these programs is elective. There is no charge for participation, and no loss of benefits for electing not to participate.

1. **High-Risk Pregnancy**
   The Plan's High-Risk Pregnancy Care program is available to Covered Persons at any stage of Pregnancy. It is designed to improve the prenatal care of the mother and fetus through education and counseling, in order to reduce the incidence of premature or underweight birth and other complications of Pregnancy and delivery.
2. **Large Case Management**
   In selected cases involving complicated, high-risk, or very costly treatment, professional advisers from the Plan's medical Network Sponsors will offer education and advice to the Covered Person with the aim of assisting in selection of alternative courses of treatment and improving the outcome. Case Managers also assist with discharge planning from an inpatient stay.

F. COVID-19 Benefits

1. **COVID-19 Testing Coverage**
   All cost-sharing amounts (i.e., deductibles, coinsurance, and copayments) and prior authorization and medical management requirements under the Plan's Medical Benefit are waived with respect to the following COVID-19 testing and certain related services received on or after March 18, 2020:
   - COVID-19 testing using a product approved for the detection of SARS-CoV-2 or diagnosis of the virus that causes COVID–19 and the administration of the COVID-19 test; and
   - Covered items and services furnished to a participant during a health care provider office visit (including both in-person and telehealth visits), urgent care center visit or emergency room visit that results in an order for or administration of a COVID-19 test using a covered in vitro diagnostic product, but only to the extent such items and services relate to (i) the furnishing or administration of such product, or (ii) the evaluation of the participant for purposes of determining the need for COVID-19 testing.

   The waiver of the cost-sharing amounts for COVID-19 testing and related services will be administered consistent with the Families First Coronavirus Response Act ("FFCRA"), as amended by the Coronavirus Aid, Economic Relief and Security Act ("CARES Act") and subsequent regulatory guidance and will

continue for the duration of the public health emergency declared by the U.S. Department of Health and Human Services on January 31, 2020 and any renewal, to the extent mandated thereunder.

2. **COVID-19 Preventive Services**

   In accordance with the CARES Act, items, services, and immunizations that are intended to prevent or mitigate COVID-19 and that are either:

   (a) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or

   (b) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention will be covered by the Plan's Medical Benefit within 15 business days after such recommendation and the cost-sharing amounts (i.e., Deductibles, Copays, and Coinsurance) will be waived with respect to such items, services, or immunizations, subject to application of reasonable and customary allowed amounts for covered services and supplies obtained from an Out-of-Network Provider.

Section III

Prescription Drug Benefit

A. Levels of Benefit

The Platinum Plan's Prescription Drug Benefit provides benefits for Medically Necessary prescription drugs, and also for some Preventive medications. This Section III contains terms and conditions applicable to prescription coverage. **Note:** The Prescription Benefit Schedule below does not apply to prescriptions obtained from the Carpenters Wellness Centers. Please refer to Section II.A.2(a) for Wellness Center information.

Plan benefits for covered prescription drugs are set forth in the following table:

PRESCRIPTION BENEFIT SCHEDULE	Minimum Copay	Plan Coinsurance	Out-of-Pocket Limit**
Retail Pharmacy (30-day supply)			
Generic Medication	$10	90%	Maximum $50
Preferred Drug Medication	$20	65%	Maximum $75
Non-Preferred Medication	$20	60%	Maximum $125
Diabetes and Insulin Supplies (including short-term continuous glucose monitors)	$10	90%	Maximum $50
Retail Pharmacy (31 to 90-day supply)			
Generic Medication	$20	90%	Maximum $125
Preferred Drug Medication	$40	65%	Maximum $200
Non-Preferred Medication	$40	60%	Maximum $350
Diabetes and Insulin Supplies	$20	90%	Maximum $125
Home Delivery (Mail Order) Pharmacy (90-day supply)			
Generic Medication	$20	90%	Maximum $100
Preferred Drug Medication	$40	65%	Maximum $150
Non-Preferred Medication	$40	60%	Maximum $250
Diabetes and Insulin Supplies	$20	90%	Maximum $100
Specialty Medications			
Preferred Drug Medication	$40	65%	$150
Non-Preferred Medication	$40	60%	$250
SaveonSP Program Specialty Drugs Specialty drugs identified on the Carpenters' Health and Welfare Trust Fund of St. Louis SaveonSp Specialty Drug List.	Copayment amount identified on the Carpenters' Health and Welfare Trust Fund of St. Louis SaveonSp Specialty Drug List		
Individual Annual Out-of-Pocket	$3,350		
Family Annual Out-of-Pocket	$7,000		

* Specialty medications approved by FDA on or after 1/1/2013 may be assigned preferred or non-preferred Coinsurance levels by the Board of Trustees.
**Per script, except Family Annual Out-of-Pocket.

As shown in the above Schedules, benefits are higher for generic than for brand name drugs, and within brand name, benefits are higher for preferred medications, which are those listed on the Plan's formulary, than for non-preferred medications. The Plan adopts as its formulary the formulary recommended by its Pharmacy Benefit Manager and Network Sponsor.

B. Covered Drugs

1. General Conditions of Coverage

Except as otherwise expressly stated in the Plan, drugs are covered for benefits only if they are:

(a) Prescribed by a Physician; and

(b) Legally required to be prescribed, except medications available over the counter (OTC) without prescription that are expressly covered in the Plan; and

(c) FDA approved for the condition for which prescribed; and

(d) Medically Necessary; and

(e) Obtained from an In-Network Provider, except for Emergency care when an In-Network Provider is not reasonably accessible as determined by the Trustees.

Insulin syringes and test strips are treated as required to be prescribed, whether or not available OTC.

Compound medications are covered only if approved in advance under criteria established by the Plan's prescription drug Network Sponsor, which are adopted and included by reference. A request for approval must be submitted to the Network Sponsor, and will not be considered if lacking any of the following elements:

- Identification of all ingredients; and
- Cost of each ingredient; and
- Supporting clinical evidence.

Compound medications that have a commercially available non-compound alternative are not covered. Approval of a compound drug applies only to ingredients as submitted.

2. Services and Supplies Covered as Preventive Medications

The drugs, services and devices listed in the following table are eligible for coverage as follows:

- Only if prescribed by a Physician; and
- Only if obtained from an In-Network Provider; and
- Regardless of whether legally required to be prescribed; and
- Regardless of Medical Necessity, unless otherwise stated Benefits for Preventive services and supplies listed in this table are payable without cost-sharing; i.e., payable at a 100% Coinsurance rate without any deductible or Copayment. Inclusion of a service or supply in this table, alone, does not guarantee benefits are payable.

The drugs, services and devices listed in the following table are intended to conform to all the following:

- Recommendations of the United States Preventive Services Task Force with rating of A or B; and
- For women, infants, children and adolescents, guidelines supported by the Health Resources and Services Administration, all of which are referred to herein jointly as the "Preventive Recommendations." The Preventive Recommendations are incorporated herein by reference, and the provisions of this Subsection B,2 shall be interpreted accordingly. The table that follows shall be automatically amended as necessary from time to time to conform to future changes in the Preventive Recommendations.

Drug or Drug Category	Criteria for Coverage	Limitations
Aspirin prescribed to prevent cardiovascular events	Men age 45 – 79; Women age 55 – 79 years	Generic OTC Products
Oral Fluoride	Children > 6 months of age through 5 years old	Generic OTC & RX Products
Folate Supplements	Women through age 50 years	Generic OTC & RX Products
Iron Supplements	Children age 6 to 12 months at risk for iron deficiency anemia	Generic OTC & RX Products
Smoking Cessation	Men and Women age 18 and over who use tobacco products	Must be enrolled in Plan's Smoking Cessation Program, Generic OTC & RX Products
Vitamin D	Men and Women age 65 and over who are at increased risk for falls	Generic OTC & RX Products
Bowel Preps	Men and Women; > 49 years of age and < 76 years of age	Generic OTC and RX Products Fill Limit: 2 prescriptions per 365 days
Contraceptives – Hormonal	Women through the age of 50 years	Generic or single source where generic unavailable, including oral, transdermal, intravaginal, injectable and implantable.
Contraceptives – Barrier	Women through the age of 50 years	Diaphragm and Cervical Cap
Emergency Contraceptive	Women through the age of 50 years	Generic and Ella

In addition, when legally supplied and administered by any licensed pharmacy, the preventive immunizations covered under Appendix C are also covered under this Section III.B.2. under the terms and conditions set forth in Section II.C.2. without cost-sharing, and regardless of whether Medically Necessary or prescribed or administered by a Physician.

C. Special Coverage Limitations

The Plan's coverage of certain drugs and drug classes is subject to additional conditions and limitations described in this Subsection C.

1. **First Line Treatment Programs**

For the drug classes listed below, drugs specified as Second Line are not covered unless the patient has first tried a prescribed course of drugs specified as First Line without medically satisfactory results or documented adverse reaction or contraindication to the First Line drug; provided, however, that Second Line drugs prescribed and used by a Covered Person before January 1, 2006 will continue to be covered for that individual without a First Line trial.

(a) **Anti-Arthritic Oral Drugs**

1) Second Line: COX-2 medications such as Celebrex

2) First Line: A traditional Non-Steroidal Anti-Inflammatory agent (NSAID) such as Ibuprofen

(b) **Anti-Arthritic Injectable**

1) Second Line: Enbrel or Humira

2) First Line: Methotrexate or other disease-modifying anti-rheumatic drug (DMARD)

(c) **Anti-Hypertensives**

1) Second Line: Any medication other than a diuretic, except as required by other medical conditions

2) First Line: A diuretic

(d) **Endocrine/Metabolic Drugs**

1) Second Line: Palynziq, covered only with Prior Authorization
2) First Line: Kuvan

2. **Supply and Dosage Limit Program**

The Plan does not cover the drugs and drug classes listed below for quantities or doses exceeding the specified limits.

(a) **Antifungal Medications Prescribed for Nail Fungus**

Coverage is limited to 90-day supply per lifetime unless Prior Authorization is obtained for a Medically Necessary additional quantity.

(b) **Anti-Migraine Medications**

Coverage is limited to dosages that do not exceed the following limits, unless Prior Authorization is obtained for a Medically Necessary higher dosage:

1) Amerge: 1 mg and 2.5 mg - (9) tablets per 30 days regardless of strength.
2) Axert: 6.25 mg and 12.5 mg - (12) tablets per 30 days regardless of strength.
3) Frova: 2.5 mg - (12) tablets per 30 days.
4) Imitrex: 25 mg, 50 mg, and 100 mg - (9) tablets per 30 days regardless of strength.
5) Imitrex Nasal Spray: (12) units or (2) packages per 30 days.
6) Imitrex Injections: (12) injections or (6) kits per 30 days.
7) Maxalt: 5 mg and 10 mg - (12) tablets per 30 days regardless of strength.
8) Migranal Nasal Spray: (8) units or (2) kits per 30 days.
9) Zomig: 2.5 mg and 5 mg - (12) tablets per 30 days regardless of strength.
10) Relpax: 20 mg, 40 mg, and 80 mg - (9) tablets per 30 days regardless of strength.

(c) **Insomnia Medications**

Coverage is limited to quantities and dosages that do not exceed the following limits, unless Prior Authorization is obtained for a Medically Necessary higher dosage:

1) Ambien and Sonata: Maximum of 14 tablets per 30-day supply regardless of dosage, and maximum of 30-day supply per claim.
2) Lunesta and Rozerem: Maximum of 30 tablets per 30-day supply regardless of dosage, and maximum of 30-day supply per claim.

(d) **Erectile Dysfunction Medications**

Coverage is limited to a maximum of 24 tablets per 90 days regardless of dosage.

(e) **Anti-infective medications for adults with acute infections caused by susceptible bacteria**

Coverage is limited to dosages that do not exceed the following limits, unless Prior Authorization is obtained for a Medically Necessary higher dosage:

1) Baxdela: Limited to 28 tablets per script.

3. **Step Therapy Programs**

(a) Selective Serotonin Reuptake Inhibitors prescribed for depression are not covered unless the patient has first tried a prescribed course of generic citalopram without medically satisfactory results.

(b) Drugs prescribed for osteoporosis are not covered unless the patient has first tried a prescribed course of generic bisphosphonate without medically satisfactory results.

(c) Nasal steroids are not covered unless the patient has first tried a prescribed course of generic fluticasone or Nasonex without medically satisfactory results.

(d) Angiotensin Receptor Blockers prescribed for high blood pressure, heart and kidney conditions or stroke are not covered unless the patient has first tried a prescribed course of generic Angiotensin Reception Blocker without medically satisfactory results.

(e) Topical and oral testosterone medications are not covered unless the patient has first tried a prescribed course of testosterone injections without medically satisfactory results. If satisfactory results are not obtained from injectables, Testim gel or Androderm patch may be considered for coverage.

(f) Rolapitant is covered, as a specialty drug, only when prescribed as an antiemetic during cancer chemotherapy and only after the patient has first tried a prescribed course of a 5-HT3 antagonist such as ondansetron (Zofran) without satisfactory medical results.

(g) Austedo is covered only after the patient has first tried a prescribed course of generic tetrabenazine without satisfactory medical results, and then only with Prior Authorization, after a recent Total Maximal Chorea Score, for a maximum of one year. Annual renewal only with Prior Authorization after a new TMCS.

(h) Dupixent is covered only with Prior Authorization and confirmed diagnosis of atopic dermatitis, documented failure or inadvisability of topical corticosteroids, and only after the patient has first tried a prescribed course of both tacrolimus and Elidel without satisfactory medical results.

(i) Uloric is covered only after the patient has first tried a prescribed course of allopurinol, unless contraindicated, without satisfactory medical results, and then only with Prior Authorization.

(j) Copiktra is covered only after the patient has first tried at least two prior therapies without satisfactory medical results, and then only with Prior Authorization.

4. **Drug-Specific Limitations**

When coverage of a drug or drug class is limited to generic drugs, coverage will be extended to a brand drug for no more than one year at a time if the attending Physician presents clinical documentation demonstrating the patient cannot tolerate the generic form, and if Prior Authorization is obtained for the brand drug. For purposes of the Plan, a “new prescription” of a drug is the patient’s first prescription for the drug, or the first prescription of the drug after an interval of at least six months during which the patient has neither taken the drug nor refilled a prescription for the drug.

The Plan’s Network Sponsors may not, unless by express approval of the Trustees, treat as covered by the Plan a new brand drug for which the Plan covers a generic or over-the-counter alternative, or a specialty drug not previously covered, nor may they add to the Plan’s Formulary or change a coverage rule of the Plan if such action would be inconsistent with recommendations of the UBC Clinical Advisory Committee that were adopted by the Plan. The Plan will not provide benefits for a drug treated as covered by a Network Sponsor in violation of this paragraph. For a list of Drug-Specific Limitations, see Appendix E.

D. Excluded Drugs

The Plan does not provide any prescription drug benefits for any of the drugs listed in Appendix F, which is subject to change and addition.

E. Network Providers

Except for Emergency care described below, the Plan pays prescription drug benefits only for drugs obtained from an In-Network Provider. All specialty prescriptions must be filled by the Specialty Network to be covered, except a specialty drug that is a limited distribution drug may be obtained from the approved issuing pharmacy. At the date of this restated Plan Document, Express Scripts is the Network Sponsor for the retail Network and Home Delivery Network. The specialty drug Network is known as Accredo Specialty Pharmacy.

As a limited exception to the In-Network requirement, the Plan will cover a drug from a Non-Network Provider to the extent Medically Necessary for Emergency care when an In-Network Provider is not reasonably accessible as determined by the Trustees.

1. **Retail Pharmacy Network**

   In general, the Plan covers up to a 30-day supply of drugs, other than maintenance or specialty drugs, obtained from a Provider in the Retail Pharmacy Network. The Plan covers up to a 90-day supply of maintenance drugs obtained from a Provider in the Retail Pharmacy Network, except the first fill of a new prescription for a maintenance drug, or a prescription for a changed dosage of a maintenance drug, is limited to a 30-day supply.

2. **Home Delivery Network**

   The Plan covers up to a 90-day supply of maintenance drugs, and up to a 30-day supply of other drugs except specialty drugs, when obtained from the Home Delivery Network, except the first fill of a new prescription for a maintenance drug, or a prescription for a changed dosage of a maintenance drug, is limited to a 30-day supply.

   Maintenance drugs are medications prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Examples of chronic conditions that may require maintenance drugs are high blood pressure, high cholesterol, and diabetes.

3. **Specialty Drug Network**

   Drugs classified by the FDA as specialty drugs are covered only when obtained from the Accredo Specialty Pharmacy, except a specialty drug that is a limited distribution drug may be obtained from the approved issuing pharmacy. Specialty drugs are generally high-cost medications for treatment of patients with refractive conditions such as oncology, psoriasis, Crohn's disease, rheumatoid arthritis, hepatitis, multiple sclerosis, HIV/AIDS, growth hormone deficiency, organ transplant, fertility, and hemophilia. All newly prescribed specialty drugs require Prior Authorization.

   For a specialty drug approved by the FDA on and after January 1, 2013, the Plan's Coinsurance rate will be 50% unless the Trustees assign to such drug the preferred (65%) or non-preferred (60%) Coinsurance rate.

   The Plan adopts and incorporates by reference the criteria of the Accredo Specialty Pharmacy to identify specialty drugs that have a high risk of intolerance or serious adverse effects warranting short-fill trials. The current list of such drugs is available by inquiry to the Plan Office or on the Plan website at www.carpdc.org/Benefits. A new prescription for such a specialty drug is covered only for a 15-day supply, for up to the first six fills, as recommended by the Accredo Specialty Pharmacy criteria.

   For all drugs classified as specialty drugs, Prior Authorization is required in accordance with the UBC Clinical Advisory Committee Specialty Med PA Process Position Statement dated August 2014.

F. Prior Authorization Requirements

As in the case of services and supplies within the Medical Benefit, the Plan specifies certain drugs or quantities for which Prior Authorization is required as a condition of receiving any prescription drug benefit. Prior Authorization, also called utilization management, is a determination made by the Plan in advance, as to whether a proposed drug is Medically Necessary. The Plan ordinarily bases this determination on advice received from medical professionals, who may be furnished by Network Sponsors or may be independent medical experts retained by the Plan.

Prior Authorization only confirms a proposed drug is considered Medically Necessary for purposes of qualifying for Plan benefits. Prior Authorization alone does not guarantee either coverage, or availability of benefits. Prior Authorization is not intended, and should not be used, as medical advice about the appropriate course of medical treatment, which remains the exclusive responsibility of the Covered Person and attending Physician.

The Plan contracts for its prescription drug Network Sponsor to furnish Prior Authorization advice concerning a proposed drug. In-Network Providers are responsible for obtaining any required Prior Authorization for drugs they dispense. Because the Prescription Drug Benefit is generally limited to In-Network Providers, a Covered Person is not required to initiate a request for Prior Authorization except in the case of a drug administered in the course of Emergency care when an In-Network Provider is not reasonably accessible as determined by the Trustees.

In the case of such emergent care, the Covered Person or attending Physician must request Prior Authorization by calling the Plan's prescription drug Network Sponsor no later than the next business day. Prior Authorization is satisfied only if certified by the Network Sponsor.

If a Covered Person fails to make timely request for Prior Authorization of a drug obtained from a Non-Network Provider, no benefits will be paid for such drug unless the Covered Person demonstrates good cause for the untimely request, is granted retrospective review of Medical Necessity, and establishes Medical Necessity, according to the procedure set forth in Section II.D.3.

Either at the time of an initial benefit determination, or on retrospective review or Appeal, the Plan, in its discretion, may act upon Prior Authorization advice received from the Network Sponsor, or may request a second opinion from an independent professional source.

G. Amount of Benefit

For coverage, the Allowable Amount for a script is the lesser of the amount charged or the uniform charge that the Provider has agreed to accept as a Member of the Network. No deductibles are applicable. If a drug obtained in an Emergency from a Non-Network Provider is covered, the Allowable Amount is the amount charged, not to exceed the lesser of Average Wholesale Price and Maximum Allowable Cost as determined by the Network Sponsor, and reduced as necessary to conform to any other specific limitations set forth in the Plan.

The Plan will pay the Allowable Amount multiplied by the Coinsurance rate set forth in the applicable Schedule of Benefits, and the Covered Person must pay a Coinsurance share equal to the balance of the Allowable Amount for the script. However, if the Covered Person's Coinsurance share is less than the Minimum Copay shown in the Schedule of Benefits, then the Covered Person must pay the Minimum Copay and the Plan will pay the balance of the Allowable Amount. If the Covered Person's Coinsurance Share is more than the per-script Out-of-Pocket Maximum shown in the Schedule of Benefits, the Covered Person is required to pay only the Out-of-Pocket Maximum amount, and the Plan will pay the balance of the Allowable Amount.

When the amount of Copay and Coinsurance payments made in a calendar year by any one Covered Person equals the Individual Annual Out-of-Pocket Maximum, no additional minimum Copays are charged to that Covered Person, and the Plan's Coinsurance rate becomes 100%, for all covered prescriptions filled during the remainder of the same calendar year for that Covered Person.

When the combined amount of Copay and Coinsurance payments made in a calendar year by any combination of a Member and the Member's Dependents equals the Family Annual Out-of-Pocket Maximum, no additional minimum Copays are charged, and the Plan's Coinsurance rate becomes 100% for all covered prescriptions filled during the remainder of the same calendar year for the Member and all the Member's Dependents.

The Plan adopted the SaveonSP Program for coverage of the specialty drugs identified on the St. Louis – Kansas City Carpenters Regional Health Plan SaveonSP Specialty Drug List, as may be amended from time to time and which is incorporated herein by reference. The specialty drugs identified on the St. Louis – Kansas City Carpenters Regional Health Plan SaveonSP Specialty Drug List are not classified by the Plan as "essential health benefits" within the meaning of Section 1302(b) of the PPACA. For coverage under the benefit schedules, Copay payments made in a calendar year by a Covered Person for SaveonSP Program specialty drugs identified on the St. Louis – Kansas City Carpenters Regional Health Plan SaveonSP Specialty Drug List do not count toward satisfying the Individual Annual Out-of-Pocket Maximum or the Family Annual Out-of-Pocket Maximum.

Copay payments for SaveonSP specialty drugs shall be administered in compliance with the SaveonSP Program and the applicable terms of the Plan. A Covered Person who enrolls in the SaveonSP Program shall be eligible for reimbursement through SaveonSP for the amount of his or her Copay payments for SaveonSP Program specialty drugs. A Covered Person who does not enroll in the SaveonSP Program shall not be eligible for Copay payment reimbursements through SaveonSP.

Section IV
Dental Benefit

A. Eligibility

The Platinum Plan's Dental Benefit is provided automatically, without additional contributions or Premium, to Members in the Active Classification and their Dependents. The Dental Benefit is available as optional coverage, at an additional Premium determined periodically by the Trustees, to Members and Dependents in the Non-Active Classification including Members and their Dependents enrolled in the UHC Medicare Advantage Program. The Dental Benefit may be elected at the time of initial enrollment in the Non-Active Classification, or at the time of enrollment in the UHC Medicare Advantage Program, or during an Open Enrollment period of October 1 through December 15 of each year. If the Dental Benefit is dropped after having been elected, it may not be reinstated.

The Dental Benefit is self-funded by the Plan. The Plan has contracted with Delta Dental, LLP to process dental claims, and for access to the Dental Network. Therefore, all claims for dental benefits must be submitted directly to Delta Dental, regardless whether from In-Network or Non-Network Providers.

B. Covered Dental Services and Supplies Procedures

Covered Dental Services and Supplies are covered for benefits only if they are:

1. Billed using approved American Dental Association (ADA) codes; and
2. Performed by a licensed Dentist (DDS or DMD), or by a licensed dental hygienist under the supervision of a Dentist; and
3. Within the standard of care of the dental profession, as determined by the Plan; and
4. Medically Necessary, except if listed as Preventive; and
5. Not excluded or limited by the provisions of this Section IV.

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
PREVENTIVE SERVICES	
Diagnostic and Preventive Services	Services and procedures used to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Includes oral examination, prophylaxes (cleanings) and topical applications of fluoride. • Oral examinations and prophylaxes (cleanings) performed twice in a calendar year; if Medically Necessary, prophylaxes can be covered for up to four times per calendar year. • Fluoride treatments performed twice in a calendar year for patients up to age 19. • Brush biopsy to detect oral cancer.
Emergency Palliative Treatment	Nonspecific treatment used on an emergency basis to temporarily relieve pain.
Radiographs	X-rays as required or in conjunction with the diagnosis of a specific condition. • Bi-wing radiographs performed twice in a calendar year. • Full-mouth radiographs (which includes bitewing X-rays) performed once every three years.

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
Healthy Smiles, Healthy Lives Program	Two additional cleanings per calendar year for individuals with documented periodontal disease, diabetics with periodontal disease, pregnant women with periodontal disease, individuals with certain high-risk medical conditions such as kidney failure, organ or bone marrow transplant recipients, individuals receiving dialysis, chemotherapy, radiation treatment, individuals who are HIV positive or are at risk for infective endocarditis. For individuals age 19 and older undergoing head and neck radiation, fluoride applications are covered twice per calendar year.
BASIC BENEFITS	
Sealants	Applied to the occlusal surface of molars that are free from caries and restorations, once per tooth per lifetime. • Benefits are payable for first and second permanent molars up to age 19 only.
Oral Surgery Services	Extractions and other surgical dental procedures; includes pre-operative and post-operative care.
Endodontic Services	Procedures used for the treatment of teeth with diseased or damaged nerves (root canals).
Periodontic Services	Procedures used for the treatment of diseases of the gums and supporting structures of the teeth including gum disease. This includes periodontal maintenance following active therapy (periodontal prophylaxes).
Minor Restorative Services	Services used to rebuild, repair, or reform the tissues of the teeth; includes amalgam, restorations (repair of crowns, or onlays), resin restorations, and relines and repairs to prosthetic appliances (bridgework and dentures).
MAJOR BENEFITS	
Prosthodontic Services	Services and appliances that replace missing natural teeth; includes fixed bridgework, partial dentures, complete dentures, and implants at the alternate treatment allowable.
Major Restorative Services	Services used to rebuild, repair or reform the tissues of the teeth when the teeth cannot be restored with another filling material, includes replacement of cast restoration (crowns), and jackets.
ORTHODONTIC BENEFITS	
Orthodontic Services	Services, treatment, and procedures required for the correction of malposed teeth.

C. Levels of Benefit

1. Network Providers

The Plan's contracted Network Sponsor at the date of this restated Plan Document is Delta Dental of Missouri for covered dental services. Covered Persons have access to the Delta Dental PPO Network and the Delta Dental Premier Network. Covered Persons are free to choose to obtain covered services and supplies from Providers in the PPO or Premier Networks or from Non-Network Providers. The Plan allows for higher benefits for Providers in the PPO Network than for Providers in the Premier Network or Non-Network Providers.

In-Network dental Providers are named and updated on the Delta Dental website at www.deltadentalmo.com/carpdc.

2. **Deductibles, Coinsurance and Maximum Benefit Limits**

There are three levels of dental benefits payable for Covered Services, as set forth in the following table:

LIMITATION	PPO NETWORK	PREMIER NETWORK	NON-NETWORK
Annual Deductible Preventive Services	Member Pays $0	Member Pays $50	Member Pays $75
Annual Deductible All Other Services, Cumulative	Member Pays $50	Member Pays $75	Member Pays $75
Preventive Services	Member Pays 0% Plan Pays 100%	Member Pays Deductible and 25% Plan Pays 75%	Member Pays Deductible and 50% Plan Pays 50%
Basic Services	Member Pays Deductible and 20% Plan Pays 80%	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 75% Plan Pays 25%
Major Services	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 60% Plan Pays 40%	Member Pays Deductible and 75% Plan Pays 25%
Orthodontic Services	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 50% Plan Pays 50%
Annual Maximum Benefit, excluding Orthodontia*	Max Advantage** plus $1,500	Max Advantage** plus $1,500	Max Advantage** plus $1,500
Lifetime Maximum Benefit, Orthodontia Only	$1,500	$1,500	$1,500

*Per Covered Person, except for Dependent Child prior to 19th birthday.
**Refer to Section IV.C.3 of the Plan Document regarding definition and detailed information regarding Max Advantage.

Note: The Dental Benefit Schedule above does not apply to dental services obtained from the Carpenters Wellness Centers. Please refer to Section II.A.2(a) for Wellness Center information.

The annual dental deductible is the amount of covered dental expenses each Covered Person must pay each calendar year before receiving any dental benefits from the Plan. The deductible is waived for Preventive services obtained by a Dependent Child prior to their 19th birthday from any Provider, and for Preventive services obtained by any Covered Person from a Delta Dental PPO Provider. The deductible paid for Preventive services counts toward the deductible for all other services, however, the deductible paid toward non-Preventive Services does not count toward the deductible for Preventive Services.

The annual maximum benefit payable by the Plan for all covered dental services except orthodontia incurred in a calendar year for each Covered Person is $1,500 plus Max Advantage benefits, but this limit does not apply to Dependent children before their 19th birthday for Preventive dental services.

The lifetime maximum benefit for covered orthodontia expenses incurred by a Covered Person is $1,500. Medically Necessary orthodontia for individuals up to age 19 years is not subject to the orthodontia lifetime maximum. Medically Necessary orthodontia must be reviewed and approved by the Network Sponsor.

3. **Max Advantage**

The Max Advantage feature means the Annual Maximum Benefit limit does not include the Covered Services listed below:

CDT CODE	DESCRIPTION
D00120	Periodic Oral Evaluation
D00140	Limited Oral Evaluation
D00145	Oral Evaluation for a Patient under three years of age and counseling with Primary Caregiver
D00150	Comprehensive Oral Evaluation
D00160	Detailed and Extensive Oral Evaluation
D00180	Comprehensive Periodontal Evaluation
D00210	Intraoral – complete series of radiographic images
D00220	Intraoral – periapical first radiographic image
D00230	Intraoral – periapical each additional radiographic image
D00240	Intraoral – occlusal radiographic image
D00250	Extraoral – first radiographic image
D00260	Extraoral – each additional radiographic image
D00270	Bitewing – single radiographic images
D00272	Bitewings – two radiographic images
D00273	Bitewings – three radiographic images
D00274	Bitewings – four radiographic images
D00277	Vertical bitewings 7 – 8 radiographic images
D00290	Posterior – anterior or lateral skull and facial bone survey radiograph image
D00330	Panoramic radiographic image
D01110	Prophylaxis – adult
D01120	Prophylaxis – child
D01206	Topical application of fluoride varnish
D01208	Topical application of fluoride – excluding varnish
D04910	Periodontal maintenance

4. **Special Accident Benefit**

   The Plan provides extra coverage for dental treatment of accidental injuries to teeth or restorations. These services are covered only with Prior Authorization, except for Emergency services. Benefits obtained in either the PPO or Premier Network will be paid at 90% of the allowable amount. Out-of-Network services are subject to the usual and customary limit and will be paid at 50% of the allowable amount. Services approved and paid under this benefit will not be subject to the annual or lifetime maximums but are subject to the annual individual dental deductible.

D. Determination of Benefit Amounts

The Allowable Amount is the maximum benefit the Plan would pay on a claim if the Coinsurance rate were 100% and if no deductible were applicable. The Plan's Allowable Amount for an In-Network claim is the uniform charge the Network Provider has agreed to accept as a member of the Network. The Plan's Allowable Amount for a Non-Network claim is the lesser of the billed charge or the reasonable and customary amount. The reasonable and customary amount applied to Non-Network claims is equal to the Delta Dental PPO contracted rate for the same procedure.

Upon receiving a claim for services and supplies covered under the Dental Benefit, the Plan will subtract from the Allowable Amount the unpaid portion of the claimant's annual deductible. The result multiplied by the Plan's coinsurance percentage equals the benefit payable by the Plan; provided, however, the amount of Plan benefits payable is also subject to all the following limitations:

1. No benefit will be paid exceeding an applicable annual or lifetime maximum benefit unless specifically noted; and
2. No benefit will be paid for dental services performed outside a dentist's office if required Prior Authorization was not obtained; and
3. No benefit will be paid under the Special Accident Benefit if Prior Authorization was not obtained; and
4. If there are two or more possible methods of treating a particular dental condition, then regardless which method is employed, benefits are limited to the benefits payable for the least costly treatment within the standard of care; and
5. No benefit will be paid for services and supplies listed in the dental limitations and exclusions set forth in this Subsection F.

For In-Network claims, a Covered Person is responsible for the difference between the amount the In-Network Provider has agreed to accept as a member of the Network and the Plan benefits payable. For Non-Network claims, the Covered Person is responsible for the difference between the billed charge and the Plan benefits payable. Network Providers may not bill an amount more than the uniform charge the Provider has agreed to accept as a member of the Network; whereas Non-Network Providers are not limited in the amount they may charge. There is no Out-of-Pocket Maximum applicable to the Dental Benefit.

E. Prior Authorization and Predetermination of Benefits

No Plan benefits are payable for a claim under the Special Accident Benefit, or a claim for covered dental procedures proposed to be performed in an Ambulatory Surgical Center or Hospital, unless Prior Authorization was obtained before commencement of services confirming both the facility and the procedures are Medically Necessary and within the standard of care. The Plan contracts for Delta Dental to furnish Prior Authorization advice for the Dental Benefit. A Covered Person is responsible for ensuring that required Prior Authorization is obtained for services of a Non-Network Provider. Requests for Prior

Authorization must be submitted to Delta Dental. The procedures set forth in Subsection D,2 and D,3 above will apply. Prior Authorization alone does not guarantee either coverage, or availability of benefits.

There is no Prior Authorization requirement for other services and supplies covered under the Dental Benefit received in an office setting. However, a Covered Person can obtain a predetermination of Plan benefits payable for a proposed course of treatment for which expected charges exceed $300 if the dentist's treatment program is submitted to Delta Dental before services are performed. The submission should include details of the condition of the patient's mouth, the Dentist's proposed services, and the charges for those services. Delta Dental will notify the patient and Dentist of its determination of Medical Necessity, any alternative courses of treatment that could affect the benefits payable, and the estimated benefits payable based on the planned course of treatment.

F. Limitations and Exclusions

Irrespective of all other provisions, no dental benefits will be paid for or in connection with:

1. Services or supplies for which the Covered Person, absent Plan coverage, would normally incur no charge, such as care rendered by a Dentist to a Member or Dependent.
2. Services or supplies arising out of the course of any occupation or employment for compensation, profit or gain, or for which the Covered Individual may be entitled to or receives benefits under any applicable Workers' Compensation Act, Occupational Disease policy or similar law (including settlement of a claim).
3. Any service or supply not performed or furnished by a Dentist, except X-rays ordered by a Dentist and services by a licensed dental hygienist under the Dentist's supervision.
4. Services or supplies performed for cosmetic purposes or to correct congenital malformations.
5. Charges not reasonably necessary or customarily provided for the Covered Individual's dental condition.
6. Services furnished by or for the U.S. government or any other government unless payment by the patient is legally required, or to the extent provided under any governmental program or law under which the patient is, or could be, covered.
7. A denture or fixed bridgework or adding teeth thereto, or a crown or gold restoration, if the denture, fixed bridge, crown, or gold restoration is a replacement or modification of one installed less than five years previously, except when due to an Accidental Injury. If an existing bridge or denture cannot be repaired satisfactory, a replacement will be covered only once in five years, provided that the 5-year limitation will not apply to a replacement required to treat accidental Injury that occurred while denture, fixed bridgework, crown, or gold restoration was in place.
8. Services or supplies related to temporomandibular joint (TMJ) dysfunction.
9. Duplication or replacement of lost or stolen appliances.
10. Diseases contracted or injuries or conditions sustained as a result of any act of war.
11. Denture adjustments for the first six months after the dentures are initially received.
12. Repair or replacement of an orthodontic appliance.
13. Tooth preparation, temporary crowns, bases, impressions and anesthesia or other services which are part of the complete dental procedure. These services are considered components of and included in the fee for the complete procedure.
14. Analgesia, including Nitrous Oxide, other than local.
15. Duplication of radiographs or temporary appliances.

16. Any dental services to the extent that benefits are payable under the Medical Benefit of this Plan.
17. Services rendered beyond the scope of the Provider's license or services or supplies that do not meet accepted standards or dental practice or that are Experimental or Investigative.
18. Oral hygiene and dietary instruction or plaque control programs.
19. Failure to keep a scheduled appointment with the dentist.
20. Completion of claim forms.
21. Charges for personalization or characterization of dentures.
22. Charges for services or supplies cosmetic or reconstructive in nature, unless required as a result of an accidental Injury and provided as soon as medically appropriate. Cosmetic and reconstructive procedures alter appearance but do not restore or improve impaired physical function. Tooth whitening treatments and facings on crowns, or pontics, posterior to the second bicuspid will always be considered cosmetic.
23. Charges for medications, infection control or medical waste disposal.
24. Diagnosis and treatment of an Injury or Sickness resulting from participation in, or as a consequence of having participated in, commission of any felony.
25. Benefits for routine examinations and cleanings are limited to two per calendar year, except as provided in the Healthy Smiles Healthy Lives program. A PPO Network Provider must be used for routine exams and cleanings in order for the Preventive benefit with no deductible to apply.
26. Services or supplies received as a result of any Injury or Sickness sustained due to the act or omission of a third party, unless the Covered Person has fully complied with the reimbursement and subrogation provisions of this Plan.
27. Charges for fluoride or sealants are limited to Dependents prior to their 19th birthday.
28. Coverage for multiple radiographs on the same date of service will not exceed the coverage level for a complete mouth series. A panoramic film, with or without other films, is treated as a full mouth series for coverage purposes.
29. Endodontic (root canal) treatment on the same tooth is covered only once in a 2-year period.
30. Charges for replacement of filling restorations are only covered once in a 24-month period, unless damage to that tooth was caused by Accidental Injury.
31. If a Covered Person's eligibility is terminated before an orthodontic treatment plan is completed, coverage of the treatment will be provided only to the end of the month of termination.
32. If care is received from more than one Provider for the same procedure, benefits will not exceed what would have been paid to one Dentist for the procedure (including, but not limited to, prosthetics, orthodontics, and root canal therapy).
33. Sealants are limited to caries-free occlusal surfaces of the first and second permanent molars up to age 19 only.
34. All Coordination of Benefit Rules, definitions, filing limits and other limitations applicable to the medical plan are also applicable to the dental plan (see Section IX on Multiple Coverage Limitations).

G. Claims for Dental Benefits

Claims must be filed within 365 days from the day which services were rendered to be eligible for Plan benefits. The Plan will not pay claims submitted after this period. If a claim is denied due to a PPO or Premier Network Provider's failure to make timely submission, the Covered Person will not be liable to such Provider for the amount which would have been payable by the Plan, provided the Covered Person

advised the Provider of eligibility for Plan benefits at the time of treatment. A Covered Person who obtains services and supplies from a Non-Network Provider is responsible for filing a timely claim for reimbursement with Delta Dental.

H. Additional Plan Definitions – Dental

1. "Accidental Injury" means an Injury to a tooth, teeth or restoration caused by a physical Injury resulting from an accident not related to the normal function of the tooth or teeth.
2. "Delta Dental PPO" or "PPO" means the preferred Provider organization available through Delta Dental of Missouri.
3. "Dentist" means a dentist duly licensed and legally qualified to practice dentistry at the time and place covered dental services are performed.
4. "Premier Dentist" means a Dentist or service Provider who is a member of the Delta Dental Premier Network.
5. "Non-Network Dentist" means a Dentist or service Provider who is not a member of either the Delta Dental Premier Network or the Delta Dental PPO Network.
6. "In-Network Dentist" means a Dentist or service Provider who is a member of either the Delta Dental Premier Network or the Delta Dental PPO Network.
7. "PPO Dentist" means a Dentist or service Provider who is a member of the Delta Dental PPO Network.

Section V
Vision Benefit

A. Eligibility

The primary purpose of the Platinum Plan's Vision Benefit is to assist eligible Members and Dependents to obtain eyeglasses or contact lenses to improve visual acuity. The Vision Benefit is provided automatically, without additional contributions or Premium, to eligible Members and Dependents not enrolled in the UHC Medicare Advantage Program.

The Plan has contracted with Vision Service Plan (VSP) to process claims in the Vision Benefit, to make Prior Authorization determinations, and for access to a vision Network. Therefore, all claims for vision benefits must be submitted directly to VSP, regardless whether from In-Network or Non-Network Providers.

B. Levels of Benefit

1. Network Provider

The Platinum Plan's Network at the date of this restated Plan Document, for purposes of the Vision Benefit, is the Vision Service Plan (VSP) Network. Covered Persons are free to choose to obtain covered services and supplies from In-Network Providers or from Non-Network Providers. In general, Plan benefits are higher for In-Network Providers than for Non-Network Providers. In-Network vision Providers are named and updated on the VSP website at www.vsp.com.

2. Copayments and Maximum Benefit Limits

There are two levels of vision benefits, In-Network and Non-Network. The frequency limitation is the number of months that must elapse after a listed service or supply is furnished to a Covered Person before the same service or supply will again be covered for the same Covered Person. A Copayment is the amount a Covered Person must pay the Provider at the time a listed service or supply is obtained from an In-Network (VSP) Provider. Non-Network Providers require full payment at the time of service, as set forth in the following table:

VISION BENEFIT				
VISION SERVICE OR SUPPLY	**Frequency**	**Description**	**VSP Provider***	**Non-VSP Provider Maximum Benefit***
Routine Eye Examination	*Every calendar year*	Focuses on overall eye wellness	Member Pays $10 copay	Member Pays the Greater of $10 Copay or Balance after Plan Pays $38
Prescription Glasses				
Frames	*Every 24 months*	Included in Prescription Glasses	Member Pays $25 copay Plus 80% of Balance after Plan Pays $150	Member Pays the Greater of $25 Copay or Balance after Plan Pays $45
Lenses	*Every calendar year*	Single Vision	Plan Pays 100% No Member copay	Plan Pays $31 Member Pays Balance
		Lined bifocal	Plan Pays 100% No Member copay	Plan Pays $51 Member Pays Balance
		Lined trifocal	Plan Pays 100% No Member copay	Plan Pays $64 Member Pays Balance

VISION BENEFIT				
VISION SERVICE OR SUPPLY	**Frequency**	**Description**	**VSP Provider***	**Non-VSP Provider Maximum Benefit***
		Lenticular	Plan Pays 100% No Member copay	Plan Pays $80 Member Pays Balance
Lens Enhancements	*Every calendar year*	Standard progressive	Plan Pays $50 Member Pays Balance	Not covered
		Premium progressive	Plan Pays $80 - $90 Member Pays Balance	Not covered
		Custom progressive	Plan Pays $120 - $160 Member Pays Balance	Not covered
Contacts (Instead of glasses)	*Every calendar year*	Medically necessary; prior authorization	Plan Pays 100% No Member copay	Plan Pays $210 Member Pays Balance
Contacts	*Every calendar year*	Elective	Plan Pays $150 (includes lens exam) Member Pays Balance	Plan Pays $105 (does not include lens exam) Member Pays Balance
ProTec Safety® (Member-Only Coverage) with VSP Provider Only				
Frames	*Every 24 months*	VSP doctor's ProTec Eyewear® collection Certified according to the ANSI guidelines for impact protection	Member Pays $25 copay	Not covered
Lenses	*Every 24 months*	Single Vision Lined bifocal Lined trifocal Certified according to the ANSI guidelines	Included with Frames	Not covered

*Subject to additional limitations set forth below. *The services and supplies listed in the Vision schedule are covered only if performed by a licensed optometrist, ophthalmologist, or dispensing optician. Covered eye exams include an evaluation of visual function and prescription corrective lenses, if needed.*

C. Covered Vision Services and Supplies

The only services and supplies for which the Plan pays vision benefits are listed in the table set forth in Subsection B.2 above. Listed services and supplies are covered for benefits only if they:

1. Are performed or furnished by a licensed optometrist, ophthalmologist, or dispensing optician; and
2. Conform to the additional conditions and limitations set forth in Subsection D below; and
3. Are not excluded under the general exclusions set forth in Subsection G below.

D. Additional Conditions and Limitations

1. **Eye Examinations**

   Covered eye examinations include an evaluation of visual function and prescription of corrective lenses if needed.

For purposes of the VSP Provider maximum benefit, the Network scheduled amount is the amount the Provider has agreed to accept, as a member of the Network, for standard eye examinations as defined by VSP.

2. **Eyeglass Lenses and Frames**

   Lenses and frames are covered, subject to the applicable frequency limitation, provided also that benefits have not been paid for contact lenses obtained during the preceding 12 months.

   For purposes of the VSP Provider maximum benefit for lenses, the Network scheduled amount is the amount the Provider has agreed to accept, as a member of the Network, for standard lenses as defined by VSP. If a Covered Person elects to obtain non-standard lenses from a VSP Provider, including but not limited to those with any of the following features, the Covered Person will be required to pay the extra cost over the scheduled amount for standard lenses:

   (a) Optional cosmetic processes; or

   (b) Anti-reflective, color, mirror, or scratch coating; or

   (c) Blended, cosmetic, laminated, oversized and progressive multifocal lenses; or

   (d) Photochromic lenses; tinted lenses except Pink #1 and Pink #2; or

   (e) UV (ultraviolet) protected lenses.

   For purposes of the VSP Provider maximum benefit for frames, the Network scheduled amount is the amount the Provider has agreed to accept, as a member of the Network, for standard frames as defined by VSP. If a Covered Person elects to obtain non-standard frames from a VSP Provider, the Covered Person will be required to pay the extra cost over the scheduled amount for standard frames.

   Lenses and frames obtained from a VSP Provider include the following professional services:

   - Prescribing and ordering proper lenses.
   - Assisting in the selection of frames.
   - Verifying the accuracy of the finished lenses.
   - Fitting and adjustment of frames.
   - Subsequent adjustments to frames to maintain comfort and efficiency.
   - Progress or follow-up work as necessary.

   Any charges by a Non-Network Provider for such services are included in the amount subject to the Plan's maximum benefit for lenses and frames.

3. **Contact Lenses**

   Contact lenses are covered, subject to the applicable frequency limitation, provided benefits have not been paid for eyeglass lenses or frames obtained during the preceding 12 months.

   Contact lenses obtained from VSP include suitability evaluation and fitting. Any charges by a Non-Network Provider for such services are included in the amount subject to the Plan's maximum benefit for contact lenses.

   For purposes of the VSP Provider maximum benefit for Medically Necessary contact lenses, the Network scheduled amount is the amount the Provider has agreed to accept, as a member of the Network, for standard contact lenses as defined by VSP. Contacts will be considered Medically Necessary only in one or more of the following situations, and only if pre-authorized by VSP:

   (a) Following cataract surgery; or

(b) To correct extreme visual acuity problems that cannot be corrected with spectacle lenses; or

(c) With Anisometropia (unequal refraction in the eyes); or

(d) With keratoconus (corneal protrusion).

Plan benefits at the Medically Necessary level are not payable unless Prior Authorization is obtained before commencement of services, confirming the Medical Necessity of contact lenses instead of eyeglasses. The Plan contracts for VSP to furnish Prior Authorization advice for the Vision Benefit. A Covered Person is responsible for ensuring that required Prior Authorization is obtained for services of a Non-Network Provider. Requests for Prior Authorization must be submitted to VSP. The procedures set forth in sections II.D.2 and II.D.3 above will apply. Prior Authorization alone does not guarantee either coverage, or availability of benefits.

E. Additional Discount

Each Member and Dependent is entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP Network Provider. Additional pair means any complete pair of prescription glasses not covered under this Plan.

Additionally, Members and Dependents are entitled to receive a discount of fifteen percent (15%) off a VSP Network Provider's professional fees for contact lens evaluations and fittings not covered under this Plan. Discounts are applied to the VSP Network Provider's usual and customary fees for such services and are available from a VSP Network Provider who provides a covered eye examination, for services provided within 12 months after the covered eye examination. This discount does not apply to contact lens materials, which are provided at the doctor's usual and customary charges.

F. Determination of Benefit Amounts

Upon receiving a claim for services and supplies covered under the Vision Benefit and furnished by an In-Network (VSP) Provider, the Plan will pay the lesser of the billed charge or the applicable Network scheduled amount, in either case reduced by any required Copayment. If services or supplies were furnished by a Non-Network Provider, the Plan will pay the lesser of the billed charge or the maximum benefit amount set forth in Subsection B,2 above, in either case reduced by any required Copayment. In all cases, however, the Plan benefit payable is also subject to the additional conditions and limitations of Subsection D above, and the exclusions set forth in Subsection G below.

A Covered Person must pay in full the amount due a Non-Network Provider for covered services and supplies and file a claim with VSP for reimbursement from Plan benefits.

There are no deductibles, Coinsurance rates or Out-of-Pocket Maximum applicable to the Vision Benefit. The Covered Person is responsible for the portion of a billed charge in excess of the Plan benefits payable. In-Network Providers may not bill an amount in excess of the uniform charge the Provider agreed to accept as a member of the Network; whereas Non-Network Providers are not limited in the amount they may charge.

G. General Exclusions

Irrespective of all other provisions, no vision benefits will be paid for or in connection with:

1. Optional cosmetic features such as anti-reflective coating, color coating, mirror coating or scratch coating, blended lenses, cosmetic lenses, laminated lenses, oversize lenses, progressive multifocal lenses, UV (ultraviolet) protected lenses, and photochromic lenses; tinted lenses except Pink #1 and Pink #2.

2. Orthoptics or vision training, and any associated supplemental testing; Plano lenses (less than a ±.38 diopter power); or a second pair of glasses in lieu of bifocals.
3. Replacement of lenses and frames furnished under this Plan which are lost or broken, except in compliance with the frequency limitation in Subsection B.2 above.
4. Medical or surgical treatment of the eyes.
5. Any eye examination or corrective eyewear, not otherwise covered by the Plan, required by an Employer as a condition of employment.
6. Experimental or Investigative services or supplies.
7. Drugs or medications.
8. Corrective vision treatments such as RK, PRK LASIK and Custom LASIK.
9. Care, services, or supplies received as a result of any Injury or Sickness sustained due to the act or omission of a third party, unless the Covered Individual has fully complied with the reimbursement or subrogation provisions of this Plan.
10. Any vision services to the extent that benefits are payable under the Medical Benefit of this Plan.
11. Costs for services and supplies in excess of Plan maximum benefits.

H. Special Low Vision Benefit

Independent of, and in addition to, the benefits described in Subsections B through F above, the Plan offers a special low vision benefit program through VSP, under eligibility criteria established by VSP.

If an eye examination performed by a VSP Provider or Non-VSP Provider indicates a Covered Person has a severe visual problem that is not correctable with regular lenses, the Covered Person or Provider may submit a request to VSP for approval of coverage in the low vision program. Requests for pre-approval of low vision benefits must be directed to VSP Member Services at (800) 877-7195 or on the VSP web site at www.vsp.com. If the request is approved as appropriate to the particular patient under VSP criteria, the patient may obtain a complete low vision analysis that includes a comprehensive exam of visual functions and prescription of corrective eyewear or vision aids if indicated. If a VSP Provider performs the low vision analysis, a $10 Copayment applies, and the remainder is paid in full by the Plan. If a Non-VSP Provider performs the low vision analysis, the Plan benefit is the lesser of the amount charged or $125.

If the low vision analysis includes a prescription for additional therapy, corrective eyewear or vision aids, the Plan will pay an additional benefit for the prescribed items at a Coinsurance rate of 75% of the lesser of the charged amount or the amount authorized by VSP, regardless whether furnished by a VSP Provider or a Non-VSP Provider. The balance of the Provider's charge must be paid by the Covered Person.

The maximum aggregate benefit amount payable by the Plan under the special low vision benefit is $1,000 on account of all Covered Charges incurred during each successive period of 24 months, beginning when the first such Covered Charge is incurred.

I. Claims for Vision Benefits

Claims must be filed within 365 days from the day which services were rendered to be eligible for Plan benefits. The Plan will not pay claims submitted after this period. If a claim is denied due to a VSP Provider's failure to make timely submission, the Covered Person will not be liable to such Provider for the amount which would have been payable by the Plan, provided the Covered Person advised the Provider of eligibility for Plan benefits at the time of treatment. A Covered Person who obtains services and supplies from a Non-Network Provider is responsible for filing a timely claim for reimbursement with VSP.

Section VI

Short-Term Disability Benefits

The Plan provides an ancillary benefit to assist Members who are unable to work during periods of temporary Disability.

A. Eligibility for Short-Term Disability Benefits

A Member in the Active Classification who becomes temporarily Disabled because of a non-occupational accident or Sickness that occurs while eligible for medical benefits in the Plan is eligible to receive benefits under the terms and conditions stated below. For this purpose, "Disabled" means that the Member is prevented, due solely to the Sickness or Injury, from engaging in gainful employment. In addition:

1. The Member must be under the direct care and attendance of a Physician, who certifies the Member is disabled within the foregoing definition and states an expected return to work date.
2. The treating Physician must notify the Plan of any changes to the expected return to work date. In addition, the Provider may be required to submit documentation for support of continued Disability determinations at any time upon the Plan's request.
3. For Disability caused by an accident, the Member must provide the Plan with complete details of time, place, and circumstances of the accident.
4. Notwithstanding anything to the contrary, effective for the National Emergency, as defined in Section VIII.D.16, for purposes of this Section VI, a Member shall be deemed to have incurred a Sickness under the following circumstances that have an onset date within the National Emergency and with respect to which the Member satisfies the benefit eligibility requirements under this Section ("COVID-19 Deemed Sickness"):
   (a) A Member presents with a claim a statement from a medical professional (Physician or public health official) certifying that he or she (i) tested positive for coronavirus disease 2019 ("COVID-19"), including the Member's onset date of COVID-19 and an expected return to work date, or (ii) should be quarantined due to COVID-19 symptoms of the Member or due to the COVID-19 diagnosis or symptoms of a family member with whom the Member resides, including the dates of the quarantine period; or
   (b) A Member presents with a claim a statement that he or she will begin (or has begun) a quarantine period of up to 14 days, including the dates of the quarantine period, because of possible exposure to COVID-19 with respect to the Member or a family member with whom the Member resides.

Notwithstanding the above, the Trustees may prospectively extend or shorten the Outbreak period during which this Section VI.A.4 shall be effective. In addition to other requirements for benefits under this Section VI, COVID-19 Deemed Sickness benefits are (i) payable only with respect to the quarantine period or the period of the COVID-19 sickness, up to the 26-week limit under this Section, and (ii) not payable for Members who apply and qualify for state unemployment benefits with respect to the coverage period that otherwise would apply hereunder. A Member who is receiving COVID-19 Deemed Sickness benefits and whose expected return to work date is anticipated to change must notify the Plan in advance of such change and may be required to provide additional evidence to support the change.

B. Benefits Payable

Benefits are payable under this Section VI in the amount shown in the following table:

BENEFIT	AMOUNT
Short-Term Disability (Weekly Indemnity)	$300 per week

Benefits begin (i) on the first day of an accident disability, Hospital confinement or outpatient surgery or the applicable onset date of COVID-19 Deemed Sickness; or (ii) for a Sickness (other than COVID-19 Deemed Sickness) without Hospital confinement or outpatient surgery, on the eighth day after the disability onset date certified by the Member's Physician. The benefit for each day of a partial week of disability is one-seventh of the weekly benefit calculated on a minimum seven-day work period. Benefits will be paid for no more than 26 weeks during a period of disability.

Successive periods of disability, separated by less than 80 Credit Hours of work in Covered Employment, will be considered as one period of disability, unless the subsequent disability is due to an Injury or Sickness entirely unrelated to the cause of the previous disability and the two disabilities are separated by at least eight Credit Hours of work in Covered Employment. Benefits terminate on the last day of the Member's disability or, if earlier, after a maximum of 26 weeks of disability benefits have been paid.

The Plan will deduct from Short-Term Disability benefits the amount of required FICA contributions, and will issue to the Member an annual Form W-2 form reporting the amount paid under this benefit for the calendar year.

C. Exclusions

No benefits are payable under this Section VI:

1. For any day of disability which a Member is eligible for, or receiving, compensation from the Member's Employer, or Worker's Compensation benefits, even if occupational and non-occupational disabilities are unrelated.
2. For disabilities resulting from any Injury or Sickness due to the act or omission of a third party unless the Member has fully complied with the reimbursement and subrogation provisions of this Plan.
3. For periods that exceed accepted standards of disability, unless properly documented by the treating Physician.
4. For any day prior to or after the period when a Member was under treatment, and was certified as disabled, by an attending Physician, even though the Sickness or illness may have been present (except as provided regarding COVID-19 Deemed Sickness).
5. For any day on which the Trustees determine a Member was not disabled, though certified as such by a Physician.
6. For disability resulting from any Injury or Sickness for which no medical benefits are payable (except as provided regarding COVID-19 Deemed Sickness).
7. For any member while covered under COBRA.
8. For any Member or Dependent covered under Section I.A.4 as a Non-Bargained Office Employee.

Section VII

Life Insurance and Safety Enhancement Benefits

A. Life Insurance Benefits

The Plan provides Life and Accidental Death and Dismemberment (AD&D) benefits under policies insured by a commercial insurance company. The terms and conditions of such benefits are as stated in the policies, which are adopted and incorporated by reference. The coverages are summarized in this Section VII, but in case of any conflict or inconsistency, the terms of the policies will prevail. A copy of the certificate containing policy terms may be examined at the Plan Office. All claim forms needed to file for benefits under the Life insurance and AD&D policies can be obtained from the Plan Office. The insurance carrier at the date of this restated Plan Document is Metropolitan Life Insurance Company (MetLife).

1. **Eligibility for Life and AD&D Benefits**

   A Member is eligible for Life insurance and AD&D benefits so long as the Member is eligible for medical benefits under the Plan, or is enrolled in the UHC Medicare Advantage Program, except for the following Members, who are not eligible for either Life Insurance or AD&D benefits:

   (a) A Member in the Non-Bargained Office Employee group.

   (b) A Member with COBRA continuation coverage.

   A Dependent who dies while eligible for medical benefits under the Plan, or who is enrolled in the UHC Medicare Advantage Program, is eligible for Life insurance, but not AD&D benefits, except for the following Dependents, who are not eligible for either Life insurance or AD&D benefits:

   (a) An individual who did not live in the United States or Canada at the time of death.

   (b) A stillborn or unborn child.

   (c) An individual in whom the insurance company determines the related Member had no insurable interest.

   (d) A Member's Dependent in the Non-Bargained Office Employee group.

   (e) A Dependent with COBRA continuation coverage.

   No person is entitled to additional benefit amounts by virtue of being the Dependent of more than one Member.

2. **Level of Death Benefits**

   Life insurance and AD&D death benefits are payable in the amounts shown in the following table:

BENEFIT	AMOUNT
Insurance on Life of Member	$8,000
Insurance on Life of eligible Dependent	$2,000
AD&D death benefit (Members only)	$8,000

   The Life insurance benefit is payable on account of death from any cause subject, as previously noted, subject to the terms of the policies. The death benefit under the AD&D policy is payable only for accidental death. When payable under the terms of the AD&D policy, the AD&D death benefit is payable in addition to the Life insurance benefit. Under no circumstance will an amount greater than the applicable amount shown in the foregoing table be paid as benefits of this Plan on account of the

death of a Member or Dependent, except for interest that may become payable after death under the terms of the policy.

3. **Death Beneficiary**

   The proceeds payable under the Life insurance and AD&D policies as benefits on account of the death of a Member will be paid to the Member's designated beneficiary.

   A designated beneficiary is a person the Member designates in writing on the Plan's form filed in the Plan office. If more than one beneficiary is named, the proceeds will be distributed equally to them unless the Member has directed otherwise on the designation form. If any designated beneficiary predeceases the Member, that beneficiary's interest terminates and the proceeds will be paid to the surviving designated beneficiaries. If the most recent beneficiary designation form filed at the Plan office at the time of death names a Member's former spouse who was divorced or whose marriage was annulled after the form was filed, the death benefit will be paid as if the former spouse had predeceased the Member.

   In the event there is no surviving designated beneficiary, or in the event there is no beneficiary designation on file in the Plan office, the death benefit for a Member will be paid as follows:

   (a) To the Member's Surviving Spouse.

   (b) If there is no Surviving Spouse, to the Member's surviving child or children, equally.

   (c) If there are no surviving children, to the Member's surviving parents, equally.

   (d) If there are no surviving parents, to the Member's siblings, equally.

   (e) If there are no surviving siblings, to the Member's estate.

   A Member may designate or change a beneficiary at any time by signing and dating a new designation form. Any designation or change will become effective upon the Plan's receipt of the signed and dated form, and will relate back and take effect as of the date the Member signed the form, whether or not the Member is living at the time of receipt of the request, but without prejudice to the Plan or insurance company on account of any payment made before receipt of such written notice.

   Information concerning beneficiary designations will be furnished only to the Member or, after the Member's death, to the Member's personal representative or the designated beneficiary when properly identified.

   The proceeds payable under the Life insurance policy as benefits on account of the death of a Dependent will be paid to the related Member, if living. Otherwise, payment will be made at the insurance company's option, to the Dependent's parent, child, or siblings or to the Dependent's estate.

4. **Extended Life Insurance (Members Only)**

   If a Member becomes Totally Disabled before age 60 while eligible for Life insurance benefits and if the Member's eligibility for Life insurance benefits would otherwise end, the Life insurance benefit in effect on the date eligibility would otherwise end will nevertheless be paid at the Member's death, provided the Member:

   (a) Remains continuously Totally Disabled,

   (b) Submits written proof of the uninterrupted continuance of Total Disability to the insurance company as follows:

      1) The first such proof must be received within 12 months after the date the Member ceases Active Work. If the Member dies during this 12-month period, the insurance company must receive proof not more than 12 months after the date of death.

2) Thereafter, whenever the insurance company requests proof of continuing Total Disability.

(c) Submits to medical examination by a Physician selected by the insurance company whenever required by the insurance company,

(d) Does not establish a claim under the conversion privilege, and

(e) Surrenders to the insurance company any policy of personal insurance issued on the Member's life pursuant to the conversion privilege provision. The insurance company will refund Premiums paid less any dividends or other indebtedness.

For purposes of this benefit, Totally Disabled means because of a Sickness or Injury the Member cannot do the important duties of the Member's job or any other job for which the Member is fit by education, training, or experience.

5. **Life Insurance Conversion Privilege (Members and Dependents)**

If a Member's or Dependent's Life insurance coverage under the Plan ends because of termination of eligibility, such Covered Person has the right to convert to an individual policy of life insurance as described in Certificate of Coverage by making application to the insurance company.

Application for the individual policy must be made within 31 days of the date coverage under the Plan ends. If death occurs within the 31-day period, a death benefit will be paid to the decedent's beneficiary in an amount equal to that which the Member or Dependent was entitled to convert, whether or not application had been made.

B. Dismemberment Benefits

1. **Level of Benefits**

If a Member sustains an accidental loss of limb or sight, the Member will be entitled to a benefit under the terms of the AD&D policy that is a percentage of the AD&D death benefit, as shown in the following table:

FOR LOSS OF:	THE AD&D BENEFIT IS:
Life	100%
One hand, one foot or the sight of one eye	50%
Both hands, both feet, sight of both eyes or any combination of two or more of the above losses	100%

The loss of a hand or foot means severance at or above the wrist or ankle joint. Loss of sight means total and irrecoverable loss. The maximum benefit payable for all losses resulting from one accident is 100% of the death benefit. Benefits are payable only for losses that are the direct result of an accident and that occur within 90 days after the accident.

2. **Limitations on AD&D Benefits**

No benefit will be paid for losses caused or contributed to by:

(a) Physical illness, diagnosis, or treatment for the illness; or

(b) An infection, unless it is caused:

1) by an external or internal wound which was sustained in an accident; or

2) by the accidental ingestion of a poisonous food or substance; or

(c) Suicide or attempted suicide while sane; or

(d) Injuring oneself on purpose; or

(e) The use of any drug or medicine unless taken on advice of and consistently with the instructions of a doctor; or

(f) A war or war-like action in time of peace, including terrorist acts; or

(g) Committing or trying to commit a felony or being engaged in an illegal activity.

A Member may obtain a complete copy of the AD&D insurance certificate by contacting the Plan Office.

C. Safety Enhancement Benefits

1. Eligibility

The persons eligible for safety enhancement benefits under this section are as follows defined in Section I.A.1 and 1.A.2:

(a) Collectively Bargained Employees

(b) Carpenters Regional Council Employees

Safety enhancement benefits are available regardless of whether such employees have earned eligibility for medical benefits under Section I.

2. Safety Training

The Plan will provide without charge, to all persons eligible under this Subsection C, the Safety Training course known as the "10-Hour OSHA Course."

Upon completion of the 10-Hour OSHA course, the Plan will provide, without charge, to all active Members eight (8) Hours of Approved Safety Training per year to satisfy requirements of the St. Louis - Kansas City Carpenters Regional Council (CRC). Approved Safety Training courses are listed on the Plan's website. Member Training records may also be accessed from the website after logging in to the Member's account at www.carpdc.org.

The Safety Training program is administered by this Plan. Questions regarding class schedules or how to sign up may be directed to the Safety Training Department at 314.644.4800, Ext 5227, or Toll-Free at 800.332.7188, Ext 5227. In addition, courses and school links can be found from the Home Page of www.carpdc.org under the Skill Advancement menu.

3. Substance Abuse Testing

The Plan will provide without charge, to all persons eligible under this Subsection testing for the presence in blood or urine of alcohol or controlled substances under the procedures approved or modified from time to time by the Trustees.

The objective of this Drug and Alcohol Testing Program is to improve safety, productivity, and morale on all construction sites and to eliminate duplicate and redundant testing for its Members.

The Trustees have contracted with St. Louis MRO to perform testing for this program. Locations and hours of operation of drug testing facilities are:

ODACS, Inc.
836 S. Kingshighway, Cape Girardeau, MO 63703

Phone: 573.332.7711
Hours: M – F, 9 am-3 pm

Carpenters Wellness Center
1403 Hampton Ave., St Louis, MO 63139
Phone: 314.752.1100
Fax: 636.461.1691
Hours: M, W, Th, F, 8 am-4 pm; Tu 8 am- 6 pm

Southern IL Carpenters' Training School
2290 South Illinois St, Belleville, IL 62220
Phone: 618.222.9880
Fax: 618.222.9883
Hours: M 7 am-5 pm; Tu, W, Th, F, 9 am-1 pm

Kansas City Council Office
8955 E 38th Ter, Kansas City, MO 64129
Phone: 816.756.1300
Fax: 816.756.1304
Hours: M, F 8 am-4 pm; W 9 am-5 pm;
Tu, Th, 8 am-12 pm

Additional information is available in the Drug Testing and Safety Training Policy and Procedure document available on www.carpdc.org.

Section VIII
Claims and Appeals Procedure

A. Generally

A claim is a request for benefits under the Plan made by or on behalf of a Covered Person who has received covered services or supplies (a "Claimant"). A claim will be determined initially by the Plan's representatives. A Claimant who is dissatisfied with the initial claim determination may file an internal Appeal, which will be decided by Cigna National Appeals Organization ("NAO"), as designee of the Plan's Board of Trustees. In addition, a Claimant will have opportunity to seek review of Cigna's determination by filing an appeal with the Plan's Board of Trustees or their designee, and to seek independent, external review of an Adverse Benefit Determination made by the Plan.

For purposes of this Section VIII, an "Adverse Benefit Determination" is a denial, reduction or termination of, or failure to provide or make payment for, a benefit, or any rescission of coverage within the meaning of 45 CFR §147.128, whether or not based on a determination of eligibility or application of any utilization review, including failure to cover a service or supply for which benefits are otherwise provided because it is experimental, investigative or not Medically Necessary. A "final internal Adverse Benefit Determination" is an Adverse Benefit Determination upheld at completion or exhaustion of the Plan's internal Appeal process. A "final external review decision" is the decision rendered by an Independent Review Organization (IRO) at the conclusion of an external review.

To receive benefits under the Plan, a Claimant must follow the procedures set forth below, and set forth more fully in the applicable summary plan description, for the applicable benefit. The Claimant may request information about the specific diagnosis and treatment codes submitted by the health care provider from the health care provider, or (i) by going to http://www.cigna.com/privacy/privacy_healthcare_forms.html or calling the Customer Service number on the back of the ID card, or (ii) to the extent otherwise specified in the summary plan description, pursuant to the resources described in the summary plan description. A Claimant has the right to receive free of charge, upon written request, all documents, records, and other information relevant to the claim within the meaning of 29 CFR §2560.503-1. Unless otherwise specified in the summary plan description, if a Claimant has any questions, such questions should be directed to:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422

Decisions on claims and Appeals are made uniformly, in accordance with the terms and conditions of the governing Plan documents and cannot be granted or paid unless authorized by those documents.

The Plan will not, under any circumstance, consider for payment a claim for medical, prescription drug, vision or dental benefits based on charges incurred more than 12 months prior to the date a claim is filed.

B. Filing A Claim

1. Medical Benefits

A claim for medical benefits should be filed within 90 days after services are rendered. Claims for medical benefits must be filed with the Plan. In most cases, if a Claimant has paid any applicable Copayment and furnished the Provider with the Plan's Medical ID card, a claim will be filed directly by the Provider. It is the responsibility of an In-Network Provider to file accurate and timely claims with

the Plan, and if an In-Network Provider fails to do so, the Claimant will not be liable to the Provider for the Plan benefits that would have been payable. If services or supplies are obtained from a Non-Network Provider, it is the responsibility of the Claimant to see that an accurate and timely claim is filed, by the Provider or Claimant. If a Claimant pays a Provider directly, the Claimant may file a claim with the Plan for reimbursement of any Plan benefits due but not paid to the Provider by the Plan. Unless otherwise specified in the summary plan description, a claim for such reimbursement must be submitted to:

Cigna Healthcare
PO Box 182223
Chattanooga, TN 37422

2. **Prescription Drug Benefits**

The Plan has contracted with Express Scripts to process claims for the Prescription Drug Benefit, to make Prior Authorization determinations, and for access to the drug Networks. Therefore, all claims for prescription drug benefits must be submitted directly to Express Scripts, regardless whether from In-Network or Non-Network Providers.

Because prescription drug benefits are payable only for drugs purchased from an In-Network Provider (except in an Emergency), it is the In-Network Provider who is responsible for filing the claim. The filing and processing of In-Network claims is automated at the point of sale, and the Claimant will then be informed of the amount due from the Claimant.

If a Claimant obtains a covered drug from an In-Network Provider and pays the full charge because the claim for any reason is not processed at the point of sale, or if a Claimant's purchase of a drug from a Non-Network Provider is covered as an Emergency, the Claimant may file a claim for reimbursement of Plan benefits. A claim for such reimbursement must be submitted to Express Scripts on an Express Scripts Drug Reimbursement claim form, which can be obtained at www.carpdc.org or by calling the Benefit Office.

3. **Vision Benefits**

Claims for vision benefits must be filed with the Plan's Network Sponsor, Vision Service Plan (VSP). If a Claimant obtains services or supplies from an In-Network Provider and has paid any applicable Copayment and furnished the Provider with the Plan's Vision ID card, a claim will be filed directly by the Provider. It is the responsibility of an In-Network Provider to file accurate and timely claims with the Plan, and if an In-Network Provider fails to do so, the Claimant will not be liable to the Provider for the Plan benefits that would have been payable. If services or supplies are obtained from a Non-Network Provider, it is the responsibility of the Claimant to see that an accurate and timely claim is filed, by the Provider or Claimant. If a Claimant pays a Provider directly, the Claimant may file a claim for reimbursement of any Plan benefits that were due but not paid to the Provider by the Plan. A claim for such reimbursement must be submitted to VSP on a VSP claim form, which can be obtained at www.carpdc.org or by calling the Benefit Office and requesting a VSP claim form.

4. **Dental Benefits**

The Plan has contracted with Delta Dental, LLP to process dental claims, and for access to the Dental Network. Therefore, all claims for dental benefits must be submitted directly to Delta Dental, regardless whether from In-Network or Non-Network Providers. A claim for dental benefits should be filed within 90 days after services are rendered.

If a Claimant obtains services or supplies from an In-Network Provider and has paid any applicable Copayment and furnished the Provider with the Plan's Dental ID card, a claim will be filed directly by

the Provider. It is the responsibility of an In-Network Provider to file accurate and timely claims with the Plan, and if an In-Network Provider fails to do so, the Claimant will not be liable to the Provider for the Plan benefits that would have been payable. If services or supplies are obtained from a Non-Network Provider, it is the responsibility of the Claimant to see that an accurate and timely claim is filed, by the Provider or Claimant. If a Claimant pays a Provider directly, the Claimant may file a claim for reimbursement of any Plan benefits that were due but not paid to the Provider by the Plan. A claim for such reimbursement must be submitted to:

Delta Dental of Missouri
PO Box 8690
St. Louis, MO 63126

5. **Life Insurance and Accidental Death and Dismemberment Benefit**

   A claim under the Life Insurance and Accidental Death and Dismemberment (Life and AD&D) Benefit must be filed by the Claimant on the Plan's claim form at the Plan Office, 1419 Hampton Avenue, St. Louis, Missouri 63139. Notice of the loss should be given to the Plan within 20 days, and the claim form with supporting documentation should be filed within 90 days. Benefits will not be paid if the claim is filed more than 365 days after the date of the loss. If the Claimant is eligible, the Plan will forward the claim to the company that insures this benefit for determination under the terms of the insurance policy.

6. **Claims for Disability Benefits**

   As used in this Section VIII, a "disability claim" is a claim that cannot be decided without a determination of a Covered Person's Disability including, but not limited to, a claim under the Plan's "Short-Term Disability Benefits" (formerly called "Weekly Accident and Sickness Benefits").

   A disability claim must be completed by the Claimant and attending Physician on the Plan's claim form, filed by the Claimant at the Plan Office, 1419 Hampton Avenue, St. Louis, Missouri 63139 and received no later than 365 days from the initial date of disability. The plan may require additional examination of the Claimant, by a Physician chosen by the Plan, before making a determination on the claim.

   A disability claim is subject to all applicable terms and conditions of this Section, including those not expressly directed to disability claims.

C. Notification of Initial Benefit Determination/Appeals

1. **Urgent Care Claims**

   For purposes of these procedures, an "urgent care claim" is a claim for benefits for medical care or treatment with respect to, as determined by the attending Provider, the time periods applicable to non-urgent care claims that could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A health care professional with knowledge of the Claimant's medical condition may act as the Claimant's authorized representative in connection with an urgent care claim. The Plan will notify the Claimant of the Plan's benefit determination (whether adverse or not) of an urgent care claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to follow these procedures for filing the claim, or fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the proper procedures to be followed or the specific

information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking the circumstances into account, but not less than 48 hours, to provide the specified information. The Plan will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of:

(a) the Plan's receipt of the specified additional information, or

(b) the end of the period afforded the Claimant to provide the specified additional information.

2. **Concurrent Care Claims**

If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an Adverse Benefit Determination. In such a case, the Plan will notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend a previously approved course of Urgent Care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

3. **Pre-Service Claims**

For purposes of these procedures, a "pre-service claim" is a claim that is not an urgent care claim or concurrent care claim, for benefits for a service or supply for which the Plan requires Prior Authorization as a condition of receiving some or all benefits. If the Claimant fails to follow these procedures for filing the claim, the Plan will notify the Claimant as soon as possible, but not later than five days after receipt of the claim by the Plan, of the proper procedures to be followed or the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Plan (or its agent) will notify the Claimant of the Plan's determination (whether adverse or not) of a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to matters beyond the control of the Plan, additional time is needed to process a claim, the Plan may extend the time for notifying the Claimant of the Plan's benefit determination up to 15 days, provided that within the first 15 days after receiving the claim the Plan notifies the Claimant of the circumstances requiring the extension of time and of the date by which the Plan expects to make its decision. If such an extension is necessary due to a failure of the Claimant to submit the necessary information to decide the claim, notice of extension shall specifically describe the required information, and the Claimant will be afforded 45 days from receipt of the notice to provide the specified information.

4. **Post-Service Claims**

For purposes of these procedures, a "post-service claim" is a healthcare claim that is neither an urgent care claim nor a concurrent care claim nor a pre-service claim. The Plan will notify the Claimant of the Plan's Adverse Benefit Determination of a compliant post-service claim within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to matters beyond the control of the Plan, additional time is needed to process a claim, the Plan may extend the time for notifying the

Claimant of the Plan's benefit determination up to 15 days, provided that within the first 30 days after receiving the claim, the Plan notifies the Claimant of the circumstances requiring the extension of time and of the date by which the Plan expects to make its decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant will be afforded 45 days from receipt of the notice to provide the specified information.

5. **Disability Claims**

   The Plan will notify the Claimant of the Plan's Adverse Benefit Determination of a disability claim within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, additional time is needed to process a claim, the Plan may extend the time for notifying the Claimant of the Plan's benefit determination up to 30 days, provided that within the first 45 days after receiving the claim, the Plan notifies the Claimant of the circumstances requiring the extension of time and of the date by which the Plan expects to make its decision. If, due to matters beyond the control of the Plan, a decision cannot be rendered within the first extension period, the period for making the determination may be extended up to an additional 30 days, provided that within the first 30-day extension, the Plan notifies the Claimant of the circumstances requiring the extension of time and of the date by which the Plan expects to make its decision. Any notice of extension under this paragraph shall state the standards on which entitlement to a benefit is based, the unresolved issues that require an extension of time, and the additional information needed to resolve such issues, and the Claimant will be afforded at least 45 days to provide the specified information.

6. **Calculation of Time Periods**

   For purposes of these procedures, the period of time within which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the determination is tolled from the date the notification of extension is sent to the Claimant until the earlier of the date the Claimant responds to the request for additional information or the deadline for such response.

7. **Manner and Content of Notification of Initial Adverse Benefit Determination**

   The Plan will provide notice of an initial Adverse Benefit Determination to the Claimant in writing or by electronic communication, except that such notice in the case of an urgent care claim may be provided orally followed within three days by written or electronic communication. Electronic communication shall comply with requirements of 29 CFR §2520.104b-1(c)(1)(i), (iii), and (iv).

   A notification of initial Adverse Benefit Determination shall identify the claim by date of service, Provider and claim amount. The notification shall include:

   (a) The specific reason or reasons for the adverse determination.

   (b) Reference to the specific Plan provision on which the determination is based.

   (c) A description of any additional material or information necessary for the Claimant to perfect the claim with an explanation of why such material is necessary.

   (d) A statement that the Claimant may receive on request the diagnosis code, the denial code, and an explanation of the meaning of such codes.

   (e) A description of available internal Appeals and external review processes, and the time limits applicable to such procedures.

(f) A statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review.

(g) Either the specific internal rules, guidelines, protocols, or other similar criteria, if any, the Plan relied on in making the adverse determination, or a statement that such rules, guidelines, protocols, or other similar criteria do not exist.

(h) If the adverse determination is based on a Medical Necessity, experimental treatment, or similar exclusion or limit, the notification shall also include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(i) If the adverse determination concerned an urgent care claim, the notification shall also include a description of the applicable expedited review process.

(j) If the adverse determination concerned a disability claim, the notification shall include:

1) A discussion of the decision, including an explanation of the basis for disagreeing with, or not following, either (i) views, presented by the Claimant, expressed by health care professionals treating the Claimant or vocational professionals who evaluated the Claimant; or (ii) views expressed by medical or vocational experts consulted by the Plan, whether or not relied on by the Plan; or (iii) a disability determination regarding the Claimant made by the Social Security Administration and presented to the Plan by the Claimant.

2) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, within the meaning of 29 CFR§2560.503-1, to the Claimant's claim.

8. **Appeal of Initial Adverse Benefit Determinations**

If the Plan issues an initial Adverse Benefit Determination with respect to any claim other than a medical claim, the Claimant may Appeal that denial to the Plan's Board of Trustees, under the following procedures. The Board of Trustees may delegate authority to decide such Appeals to an Appeals Committee consisting of Members of the Board of Trustees. In the case of medical claims, the Board of Trustees has delegated authority to decide the Appeal of Initial Adverse Benefit Determinations to the NAO.

9. **Filing a Request for Appeal of an Adverse Benefit Determination**

A Claimant has one hundred eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to request an Appeal of the adverse determination. All requests for Appeal of an initial Adverse Benefit Determination (including all relevant information), other than denial of a pre-service claim or a denial of a medical claim, must be submitted to the Board of Trustees at the following address:

Board of Trustees
St. Louis – Kansas City Carpenters Regional Health Plan
C/O Benefit Plans Administrator
1419 Hampton Avenue
St. Louis, MO 63139

All requests for Appeal of an initial Adverse Benefit Determination with respect to a medical claim (including all relevant information), other than denial of a pre-service claim, must be submitted to the NAO at the following address:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422

All requests for appeal of a pre-service claim must be submitted to the appropriate network sponsor identified in the Plan.

In the case of an Appeal of an initial Adverse Benefit Determination of an urgent care claim, the Claimant's request for an expedited Appeal may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's determination on Appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

A Claimant who requests an Appeal shall be provided, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant, within the meaning of 29 CFR §2560.503-1, to the Claimant's claim for benefits.

A Claimant who requests an Appeal shall be entitled to submit written comments, documents, records, testimony, and other information relating to the claim for benefits.

10. **Manner of Deciding Appeals**

An Appeal will be considered and decided, without deference to the adverse initial benefit determination, by members of NAO who did not make the adverse initial benefit determination that is the subject of the Appeal, and are not subordinates of the individual who made the adverse initial determination.

The NAO shall take into account all comments, documents, records, testimony, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

If the NAO considers, relies on, or generates any new or additional evidence (not submitted by the Claimant), before making a final internal Adverse Benefit Determination, the Plan will provide such evidence to the Claimant free of charge, as soon as possible and in time to give the Claimant reasonable opportunity to respond before the deadline for issuing notice of a final internal Adverse Benefit Determination.

Before making a final internal Adverse Benefit Determination based on a new or additional rationale (other than that described in the notice of initial Adverse Benefit Determination), the Plan will provide such rationale to the Claimant free of charge, as soon as possible and in time to give the Claimant reasonable opportunity to respond before the deadline for issuing notice of a final internal Adverse Benefit Determination.

NAO shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on Appeal of any adverse initial benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental or Investigative or Medically Necessary. The professional so engaged for consultation shall be an individual who was neither consulted in connection with the adverse initial benefit determination that is the subject of the Appeal, nor the subordinate of any such individual.

The Plan provides the following Appeal rights with respect to an initial Adverse Benefit Determination. The decision of the Board of Trustees or their Delegate is final and binding with respect to consideration by the Plan.

11. **Notification of Decision on Appeal of Internal Adverse Benefit Determination**

(a) Urgent Care Claims

The Plan or its agent shall notify the Claimant of the Plan's decision on Appeal of an urgent claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for Appeal of the initial Adverse Benefit Determination by the Plan.

(b) Pre-service or Concurrent Care Claims

The Plan or its agent shall notify the Claimant of the Plan's decision on Appeal of a pre-service or concurrent care claim within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after receipt by the Plan of the Claimant's request for Appeal of the Adverse Benefit Determination.

(c) Post-service and Disability Claims

The Plan shall make a decision on Appeal of a post-service or disability claim within a reasonable period of time appropriate for the medical circumstances, but no later than thirty

(30) calendar days, from the date of receipt of the request for review, the Plan will notify the Claimant of the second level appeal decision.

(d) Calculation of Time Periods

For purposes of these procedures, the period of time within which a decision on Appeal is required to be made begins at the time the Appeal is filed in accordance with these procedures, without regard to whether all the necessary information to make a decision on Appeal accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the decision on Appeal is tolled from the date the notification of extension is sent to the Claimant until the earlier of the date the Claimant responds to the request for additional information or the deadline for such response.

(e) Manner and Content of Notice of Decision on Appeal

The Plan will provide notice of an Adverse Benefit Determination to the Claimant in writing or by electronic communication. Electronic communication shall comply with requirements of 29 CFR §2520.104b-1(c)(1)(i), (iii), and (iv).

A notification of final Adverse Benefit Determination shall identify the claim by date of service, Provider and claim amount, and shall include:

1) The specific reason or reasons for the adverse determination, with discussion of the decision.
2) Reference to the specific Plan provision on which the determination is based.
3) A statement that the Claimant is entitled to receive, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant, within the meaning of 29 CFR §2560.503-1, to the Claimant's claim for benefits.
4) A statement that the Claimant may receive on request the diagnosis code, the denial code, and an explanation of the meaning of such codes.
5) A description of available external review processes, with information regarding how to initiate an external review.
6) A statement of the Claimant's right to bring a civil action under section 502(a) of ERISA, with the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
7) Either the specific internal rules, guidelines, protocols, or other similar criteria, if any, that the Plan relied on in making the adverse determination, or a statement that such rules, guidelines, protocols, or other similar criteria do not exist.
8) If the adverse determination is based on a Medical Necessity, experimental treatment, of similar exclusion or limit, the notification shall also include either an explanation of the scientific judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
9) If the Plan obtained advice from a medical or vocational expert in connection with the Adverse Benefit Determination, the notification will identify such expert, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.
10) If the adverse determination concerned a disability claim, the notification shall include a discussion of the decision including an explanation of the basis for disagreeing with or not following either (i) views, presented by the Claimant, expressed by health care professionals

treating the Claimant or vocational professionals who evaluated the Claimant; or (ii) views expressed by medical or vocational experts consulted by the Plan, whether or not relied on by the Plan; or (iii) a disability determination regarding the Claimant that is made by the Social Security Administration and presented to the Plan by the Claimant.

If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, the notification shall so state and also state a copy of the same will be provided free of charge upon request.

If the adverse determination is based on a Medical Necessity, experimental treatment, of similar exclusion or limit, the notification shall also include a statement that an explanation of the scientific judgment for the determination will be provided free of charge upon request.

If the Plan obtained advice from a medical or vocational expert in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination, the notification will identify such expert.

12. **Second Level Appeal Review**

A claimant may request a second level appeal review with the St. Louis - Kansas City Carpenters Regional Health Plan within sixty (60) calendar days of the date of receipt of the decision on appeal. This review will include a physician reviewer or designee who wasn't involved in the original review. A request for second level appeal review should be sent with a statement of the reason(s) the appeal should be granted and any additional comments, documents, records, or other information which should be considered as part of the new review to:

Board of Trustees
St. Louis – Kansas City Carpenters Regional Health Plan
C/O Benefit Plans Administrator
1419 Hampton Avenue
St. Louis, MO 63139

13. **Notification of Decisions on Second Level Reviews**

a) Urgent Care Claim: As soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from the date of receipt of your request for a second level appeal, the Plan will notify you of the second level appeal decision.

b) Concurrent Care Claim: Within a reasonable period of time appropriate for the medical circumstances, but no later than fifteen (15) calendar days from the date of receipt of your request for a second level appeal, the Plan will notify you of the second level appeal decision.

c) Pre-Service Claim: Within a reasonable period of time appropriate for the medical circumstances, but no later than 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the Plan will notify you of the second level appeal decision.

d) Post-Service Claim: Within a reasonable period of time appropriate for the medical circumstances, but no later than thirty (30) calendar days from the date of receipt of your request for a second level appeal, the Plan will notify you of the second level appeal decision.

14. **Miscellaneous Provisions Pertaining to Claims and Appeals**

A Claimant may designate another person to act as the Claimant's authorized representative for purposes of the Plan's claims and Appeals procedures. The designation should be made on a form which may be obtained from the Plan Office. A person designated by any means other than the Plan's

approved form, or a document satisfying the requirements of a durable power of attorney for health care under the laws of Missouri, may not act as an authorized representative except as follows: A Claimant's spouse, or court-appointed guardian or conservator may act as the authorized representative of the Claimant; a parent may act as the authorized representative of an eligible Dependent Child; and a licensed health care professional with knowledge of the medical condition of a Claimant may act as the authorized representative of the Claimant in case of an urgent care claim.

The Plan's claims and Appeal procedures are intended to comply with the Department of Labor's claims procedure regulations as well as the claim requirements under the Patient Protection and Affordable Care Act (PPACA) and shall be interpreted accordingly. In the event of any conflict between this Plan Document and the applicable regulations, the regulations will control. In addition, any changes in the applicable regulations shall be deemed to amend this Plan Document automatically to conform to such changes, effective as of the date of those changes.

Under federal law a Claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if dissatisfied with an Adverse Benefit Determination. Before bringing such an action, the Claimant must exhaust the Plan's claims and Appeals procedures. Any such action against the Plan under ERISA must be filed within two years of the date of the decision of the Trustees on Appeal.

15. **External Review Process**

If a claim or internal Appeal involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) a rescission of coverage, is denied by the Board of Trustees, the Claimant will have the opportunity to request external review of the Board of Trustees decision according to the following procedure:

1) **Standard External Review Process**

Standard external review is external review that is not considered expedited (as described in this Subsection C.15.2).

a) A Claimant may file a request for external review within four months after receipt of a notice that a claim or internal Appeal was denied. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

b) Within five business days after receipt of a request for external review, the Plan will complete a preliminary review to verify that the Claimant was covered by the Plan at the time the service or supply in question was provided, that the claim or Appeal denial was not based on ineligibility for coverage, that the Claimant has exhausted the Plan's internal claims and Appeals processes (or is deemed under applicable regulations to have done so), that the claim or Appeal denial is otherwise eligible for external review, and that the Claimant has furnished all information required to process an external review.

c) The Plan will notify the Claimant in writing of whether the request is complete and the request is eligible for external review within one business day after completion of the preliminary review. If the request is not eligible for external review, the notice will explain why, and provide contact information for the Employee Benefits Security Administration. If the request is not

complete, the notice will describe the information needed, and the Plan will allow the Claimant to perfect the request within the four-month filing period or, if longer, within 48 hours after receipt of the notice.

d) The Plan will contract with at least three accredited Independent Review Organizations (IROs) and will assign eligible requests for external review to them in rotating order.

e) Within five business days after assignment of a request to an IRO, the Plan will provide to the IRO the documents and information considered by the Plan in denying the claim or Appeal.

f) Regulations provide that the IRO will (1) notify the Claimant of the request's eligibility and acceptance for review and allow the Claimant ten days to submit additional information for consideration; (2) forward any additional information submitted by the Claimant to the Plan; (3) review the claim without consideration for the previous decisions made by the Plan; and (4) provide written notice to the Plan and the Claimant of the IRO's final decision within 45 days after receiving the request for external review. The decision notice will contain the receipt date of the review, a detailed description of the evidence or documentation considered, the principal reasons for the decision, a notification of the remedies available to either party under federal law, including judicial review available to the Claimant, and contact information for health insurance consumer assistance ombudsman established under the Public Health Services Act.

2) **Expedited External Review**

If the Claimant received a claim denial involving a medical condition of the Claimant for which the time frame to complete an expedited internal Appeal would seriously jeopardize the Claimant's life, health or ability to recover maximum function, and the Claimant has filed a request for an expedited internal Appeal; or if a Claimant receives a denial of an internal Appeal involving a medical condition of the Claimant for which the time frame to complete a standard external review would seriously jeopardize the Claimant's life, health or ability to recover maximum function; or if the Appeal denial concerns a health care condition for which the Claimant received Emergency services but has not been discharged from a facility, then in any such case, the Claimant may request an expedited external review, which will be processed as follows:

a) The Plan will conduct the preliminary review immediately upon receipt of the request for expedited external review.

b) Upon determining that the request is eligible for external review, the Plan will assign the request to an IRO and transmit the required information and documents electronically or by telephone or facsimile or other available expeditious method.

c) The Plan's contract will require the IRO to provide notice of its decision to the Plan and the Claimant as expeditiously as possible, but no later than 72 hours after receiving the request for expedited external review.

D. Temporary Extension of Certain Deadlines.

On March 13, 2020, the President of the United States issued a proclamation declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (the "National Emergency"), effective March 1, 2020. Notwithstanding any provision set forth herein to the contrary and in accordance with guidance issued by the Internal Revenue Service and U.S. Department of Labor, the days during the "Outbreak Period" will be disregarded when applying the deadlines set forth in the Plan and listed below. Current applicable guidance defines "Outbreak Period" as the date commencing on the effective date of

the National Emergency and ending on the earlier of (a) one year after the original deadline determined without regard to the National Emergency, or (b) 60 days after the end of the National Emergency.

1) Special Enrollment Period. The 30-day period to exercise a HIPAA special enrollment right due to the acquisition of a new dependent or loss of other coverage and the 60-day period to exercise HIPAA special enrollment due to a termination of Medicaid or state Children's Health Insurance Program (CHIP) coverage or qualifying for Premium assistance under Medicaid or CHIP.
2) Time to File a Claim for Benefits. The 90-day period for filing a claim for medical, prescription drug, dental, and vision benefits and the 365-day period for filing a claim for short-term disability, life insurance and AD&D benefits under the Plan.
3) Time to Appeal a Denied Claim. The 180-day period following an adverse benefit determination during which a Member may file an appeal.
4) Time to Request an External Review. The four-month period following a Claimant's receipt of an eligible Adverse Benefit Determination to file a request for external review under the Plan's Medical Benefit. In addition, upon receipt of a notice that a Claimant's request for external review is not complete, the Claimant has until the end of the four-month period or, if longer, 48 hours after receipt of notice, to perfect the request.
5) Notice of Certain COBRA Qualifying Events. The 60-day deadline for a Member or Dependent to notify the Plan of a Qualifying Event that is a divorce, legal separation, loss of dependent status or of a disability determination.
6) Election of COBRA Continuation Coverage. The 60-day period following the later of the date a Qualified Beneficiary's coverage terminates under the Plan or the date of the COBRA election notice during which the Qualified Beneficiary may elect COBRA continuation coverage.
7) Payment of COBRA Premiums. The 45-day period for a qualified beneficiary to make the initial COBRA Premium payment and the monthly 30-day grace period for Premium payments thereafter.

   If any of these periods commenced prior to the March 1, 2020 effective date of the National Emergency, the deadline for the applicable period will be suspended during the Outbreak Period, and the days during the applicable period will resume being counted following the end of the Outbreak Period.

Section IX

Multiple Coverage Limitations

A. Coordination of Benefits with other Medical Plans

The medical, prescription drug, dental and vision benefits of this Plan are subject to coordination of benefits (COB). If a Covered Person is eligible to receive such benefits under both this Plan and one or more other plans, including no-fault automobile insurance, benefits will be coordinated so the total amount paid by all plans will not exceed 100% of the Allowable Expenses incurred.

Under COB, one plan is considered "primary" and the other "secondary." When this Plan is primary, it determines payment for its benefits first before those of any other plan, without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan, and may reduce the benefits it pays so that all benefits from all plans do not exceed 100% of the total Allowable Expense.

Any COB questions not addressed by the express language of this Plan will be determined in accordance with the guidelines promulgated by the National Association of Insurance Commissioner (NAIC).

B. Purpose

The purpose of COB is to:

1. Establish a uniform order of benefit determination under which plans pay claims,
2. Avoid duplication of benefits by reducing benefits to be paid by plans that do not have to pay their benefits first, and
3. Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

C. Definitions

The following terms, whether or not capitalized, shall have the meanings indicated:

1. A **"plan"** with which this Plan coordinates benefits is any arrangement that provides benefits or services for medical, prescription drug, vision or dental care or treatment, including any of the types of coverage, plans or programs listed below or any other contractual arrangements under which such benefits for an individual and their dependents can be obtained and maintained.
   (a) Any group or non-group insurance, health maintenance organization (HMO) contracts or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal or state governmental plan, as permitted by law.
   (b) Any self-insured or non-insured plan, or any other plan, arranged through any employer, trustee, union, employer organization, or employee benefit organization.
   (c) Any Hospital service pre-payment plan, medical service pre-payment plan, group practice and any other pre-payment coverage.
   (d) Any coverage for students sponsored by or provided through a school or other educational institution.
   (e) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.

   The term "plan" shall not include Hospital indemnity-type contracts, or a state plan under Medicaid.

The term “plan” shall not be applied separately to separate parts of a single plan intended to be part of a coordinated package of benefits. However, the term “plan” shall be applied separately to each program, policy, contract or other arrangement for benefits or services, or portion thereof, which itself constitutes a “plan.” The term “plan” shall also be applied separately to that portion of each program, policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits and that portion which does not.

2. **“Allowable expense”** is a health care expense, including deductibles, Coinsurance and Copayments, covered at least in part by this Plan or another plan with which benefits are coordinated. For benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense. An expense not covered by any plan coordinating benefits is not an Allowable Expense. Any expense a Provider is prohibited by law or a contractual obligation from charging a Covered Person is not an Allowable Expense. The following are examples of expenses that are and are not Allowable Expenses:
   (a) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the plans provides coverage for private Hospital room expenses.
   (b) If a person is covered by two or more plans that compute their benefit payments on the basis of regular and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   (c) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   (d) If a person is covered by a primary plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, and by a secondary plan that provides its benefits or services on the basis of negotiated fees, and if the Provider’s contract permits, the negotiated fee shall be the Allowable Expense used by the secondary plan to determine its benefits.
   (e) The amount of any benefit reduction by the primary plan because the Covered Person has failed to comply with plan provisions such as second surgical opinions, Prior Authorization or precertification of admissions, or preferred Provider arrangements, is not an Allowable Expense.
   (f) Health care expenses covered for dissimilar benefits are not Allowable Expenses. For example, in coordinating this Plan’s medical benefit, an expense covered in another plan’s dental benefit will not be considered an Allowable Expense, nor will an expense covered in another plan’s medical benefit for a service or supply excluded in this Plan be considered an Allowable Expense.
3. **“Birthday”** refers only to the month and day of a person’s birth and does not include the year in which the person was born.
4. **“Claim”** means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of services or supplies, or payment for services or supplies, or a combination.
5. **“COBRA coverage”** means continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

6. **"Coordination of Benefits"** or **"COB"** means a provision establishing an order in which plans pay their claims and permit secondary plans to reduce their benefits so the combined benefits of all plans do not exceed total Allowable expenses.

7. **"Custodial parent"** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitations.

8. **"High deductible health plan" or "HDHP"** has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The standard for what is considered a HDHP is set annually by the IRS.

D. Rules for Determining Primary Plan

When a person is covered by two or more plans, the rules for determining which plan is primary are as follows:

1. Except as provided in paragraph 2 or 3 below, a plan that does not contain a coordination of benefits provision consistent with this Plan's provision is always primary, unless the provisions of both plans state that this Plan is primary.

2. This Plan will not supersede state or federal sponsored plans. For example, Medicare, Medicaid, Tricare and Indian Health Services.

3. A plan with coverage obtained by virtue of membership in a group designed to supplement a part of a benefit package and provides that this supplementary coverage shall be excess to any other parts of this Plan is always secondary. Examples of these types of plans are coverages primarily used to provide protection from excluded benefits or services over the maximum allowed under this Plan.

4. If another plan provides benefits on an excess insurance or excess coverage basis, the plan will always be primary to this Plan.

5. If paragraphs 1, 2, 3 and 4 above do not apply, each plan determines its order of benefits using the first of the following rules that apply:

   (a) **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, Member, policyholder, subscriber, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary, and if, under federal law, Medicare is secondary to the plan covering the person as a dependent, then the order of benefits between the two plans is reversed so that the plan the plan covering the person as a dependent is primary and Medicare is secondary.

   (b) **Dependent Child Covered Under More than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

      1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

         a) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

         b) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

      2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

a) If a court decree states one of the parents is responsible for the dependent child's health care expenses or health care coverage, that plan is primary.

b) If a court decree states both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of this subparagraph 5.(b).1) above shall determine the order of benefits.

c) If a court decree states the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of this subparagraph 5.(b).1) above shall determine the order of benefits.

d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child is as follows:

i. The plan covering the Custodial parent.

ii. The plan covering the spouse of the Custodial parent.

iii. The plan covering the non-custodial parent.

iv. The plan covering the spouse of the non-custodial parent.

3) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subparagraph 5,(b),1) or 5,(b),2) above shall determine the order of benefits as if those individuals were the parents of the child.

4) For a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under his or her own spouse's plan, the rule of longer or shorter coverage applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's spouse.

5) For a dependent stepchild, this Plan will always be the secondary plan to the coverage of either natural parent.

(c) **Active Employee, Retired, or Laid-off Employee.** The plan that covers a person as a currently working active employee, that is, an employee who is neither laid off nor retired, is the primary plan for the employee and dependents. The plan covering that same person as a retired or laid-off employee is the secondary plan for the employee and dependents. However, this subparagraph (c) is disregarded if the other plan does not have the same rule, or if the rule in subparagraph D,5,(a) above (Non-Dependent or Dependent) can determine the order of benefits.

(d) **COBRA or Other Continuation Coverage.** A plan that covers a person under COBRA or other continuation coverage required by law is secondary to a plan that covers the person without continuation coverage as an employee, Member, subscriber, or retiree or as a dependent of an employee, Member, subscriber, or retiree. However, this subparagraph (d) is disregarded if the other plan does not have the same rule, or if the rule in subparagraph D.5.(a) can determine the order of benefits.

(e) **Longer or Shorter Length of Coverage.** The plan that covered the person as employee, Member, policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the Covered Person

became covered under the second plan within twenty-four (24) hours after coverage under the first plan ended.

(f) If the preceding rules do not determine the order of benefits or there is a dispute between this Plan and another plan, Allowable Expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

E. Effect of COB on the Benefits of this Plan

When this Plan coordinates benefits with another plan, either plan may be determined to be primary under the foregoing rules. A plan may consider the benefits paid or provided by another plan in calculating the benefits it will pay only when it is secondary to that other plan. The primary plan will pay benefits as if it were the only plan, without consideration of any secondary plan.

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage, and apply that calculated amount to any Allowable Expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment so that, when combined with the amount paid by the primary plan, the total benefits paid or provided for the claim by all plans do not exceed the total Allowable Expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

1. When this Plan is secondary in coordinating benefits with a primary plan, the claim for benefits from this Plan must be filed within one year from the date the Covered Charges are incurred. The claim must include a copy of the explanation of benefits issued by the primary plan, as well as a copy of the Provider's itemized bill. The filing deadline is not extended on account of delay in processing by the primary plan, or on account of later related claims.
2. If a dependent is also covered under this Plan as a Member, the Plan will coordinate benefits. However, the Plan will not pay more than 100% of the Allowable Expense.

F. Coordination with Medicare - Active Members and Dependents

This Plan will be primary to Medicare for Members in the Active Classification, and their Dependents, who qualify for Medicare due to age, with the following exceptions: The Plan will be secondary to Medicare for a Member in the Active Classification, and a Dependent of such Member, who works for a "small Employer" within the meaning of the Medicare regulations. The Plan will also be secondary to Medicare for a Member in the Active Classification, and a Dependent of such Member, who is first Entitled to Medicare because of end-stage renal disease, after 30 months of Medicare coverage.

G. Right to Receive and Release Needed Information

The Trustees are authorized to exchange with other plans, insurance companies or other persons such information as is necessary for the purpose of coordinating benefits between this Plan and any other plan. Any person claiming benefits under this Plan agrees, as a condition of receiving such benefits, to furnish to the Trustees any information necessary to implement the provisions of this Section IX.

H. Payment Adjustments

If benefit payments that should have been made by this Plan in accordance with this Section IX have instead been made by any other plan, the Trustees have the right, exercisable alone and in their sole discretion, to pay over to the plan making such payments any amounts they determine to be warranted in order to satisfy the intent of this Section IX, and amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payments, the Trustees will be fully discharged from liability under this Plan.

I. Right of Recovery

If benefit payments have been made by this Plan with respect to Allowable Expenses in excess of the total amount of payment necessary at the time to comply with this Section X, the Trustees have the right to recover such excess from one or more of the persons it has paid, or from the Covered Person for whom such benefits were paid; or any other person or organization that may be responsible for the benefits or services provided to the Covered Person. Such payment shall be returned in a lump sum or deducted from future covered claims. The amount of benefit payments made includes the reasonable cash value of any benefits provided in the form of services.

Section X

Third Party Liability – Subrogation and Reimbursement

A. Generally

1. If a Covered Person sustains an Injury or Sickness for which a third party may be or is liable to make payment or does make payment, the Plan is not obligated to pay any benefits on account of such Injury or Sickness, except as provided in this Section X.
2. If the Trustees determine, in their discretion, that there is a reasonable likelihood that a third party is liable to make payment to a Covered Person for an Injury or illness, the Trustees may withhold benefits from the Covered Person for the Injury or illness until the liability of the third party is finally determined. In their discretion, the Trustees may instead advance benefits to the Covered Person who sustained the Injury or Sickness, subject to the subrogation and reimbursement provisions of the Plan.
3. The Plan shall advance benefits for Covered Expenses related to such illness or Injury only to the extent not paid by the third party and only after the Covered Person and his or her attorney (as applicable) have entered into the Plan's written subrogation and reimbursement agreement in its entirety. If the Covered Person and/or the attorney (as applicable) fails to sign and deliver an agreement requested by the Plan, the Trustees may decline to advance any benefits before the liability of the third party has been determined.
4. A Covered Person's own automobile insurance carrier is deemed a third party with respect to uninsured or underinsured coverage.
5. Any payment made by a third party on account of an Injury or Sickness covered by the Plan is referred to herein as a "third-party recovery."
6. A Covered Person is not required to accept an advance of benefits in case of an Injury or Sickness for which a third party may be liable to make payment or does make payment. By accepting an advance of benefits related to such Injury or Sickness, the Covered Person and his or her attorney (as applicable) accept and agree to fully comply with these subrogation and reimbursement provisions of the Plan.
7. The Plan's subrogation and reimbursement rights apply to any third-party recovery paid or payable to a Covered Person or the Covered Person's representative, estate, heirs or beneficiaries, no matter how these proceeds are captioned or characterized.
8. If any third party causes or is alleged to have caused a Covered Person Injury or Sickness while covered under the Plan, the provisions of this Section X continue to apply, even after the Covered Person is no longer covered.

B. Subrogation

1. In any instance in which benefits are advanced or otherwise paid by the Plan on account of a Covered Person's Injury or Sickness, the Plan is subrogated, to the extent of benefits paid, to all rights and claims of the Covered Person against any third party who may be liable for such Injury or Sickness.
2. The Plan, after giving notice to the Covered Person and his or her attorney (as applicable), may (but is not obligated to) institute and prosecute any legal action in the name and on behalf of the Covered Person against any potentially liable third party, and if a recovery is had, the Plan shall be entitled to receive and retain therefrom the amount of benefits paid and all costs, expenses and attorney's fees incurred in obtaining such recovery, and shall pay over any excess to the Covered Person. The Trustees shall have the

right in their discretion to compromise and settle the amount of any such claim pursued directly by the Plan on behalf of a Covered Person.

3. The Plan, as subrogee of a Covered Person, shall have the right to directly receive any payment due the Covered Person on account of an Injury or Sickness for which the Plan has paid benefits, whether or not the Plan acted on behalf of the Covered Person in procuring such payment.

C. Reimbursement Obligation

1. In the event that a Covered Person shall recover any amount from a third party, by judgment, settlement or otherwise, for an act or omission causing (in whole or in part) an Injury or Sickness for which the Plan paid benefits, the Covered Person shall be obligated to immediately reimburse the Plan for all such benefits paid, on the following terms and conditions:

   (a) The amount of the Covered Person's reimbursement obligation is the full amount (100%) of benefits paid by the Plan for such Injury or Sickness, undiminished by attorney's fees or otherwise; provided, however, the reimbursement obligation shall not exceed the full amount (100%) of the third-party recovery, undiminished by attorney's fees or otherwise. The amount of the third-party recovery is the gross amount paid by a third party on account of the act or omission, irrespective of whether any part of the recovery is allocated, by judgment or agreement, to components of damage other than medical expense.

   (b) The Plan specifically rejects the "Common Fund," "Fund," and "Attorney's Fund" doctrine and is not obligated to pay, contribute to or be charged for any part of any attorney's fees or other expenses incurred by a Covered Person to obtain a third-party recovery. All such fees and expenses are the obligation of the Covered Person alone. In the event the gross amount of a third-party recovery is insufficient to pay in full the reimbursement owed to the Plan plus such fees and expenses, the Trustees may in their discretion (but are not obligated to) compromise any part of the reimbursement obligation of the Covered Person, as the Trustees deem just and in the best interest of the Plan.

   (c) The Covered Person's reimbursement obligation shall be secured by a first lien in favor of the Plan on the gross third-party recovery, prior to all other claims or liens including those for attorney's fees or those asserted by medical providers. The Covered Person shall have no right or power to defeat or diminish the Plan's lien by committing all or part of a third-party recovery to another person or entity. The Plan may notify the third party, his or her insurer, his or her attorney, or anyone else of the Plan's lien and other rights with respect to a third-party recovery.

   (d) The third-party recovery, to the extent of the Plan's interest therein, is a plan asset and the Covered Person and his or her attorney and anyone else in possession of the third-party recovery shall hold the same In Trust, either in a separate bank account in the Covered Person's name or in his or her representative's trust account, as trustee, for the benefit of the Plan, to be applied first in satisfaction of the of the Covered Person's reimbursement obligation to the Plan. The Covered Person shall be required to pay interest on any amounts held by him or her (or the Covered Person's authorized representative) which should have been returned to the Plan.

   (e) The Covered Person's reimbursement obligation is a debt owed by the Covered Person to the Plan, independent of the third-party recovery Fund. If for any reason the reimbursement obligation is not promptly paid in full by the third-party recovery Fund, the unpaid balance remains due and owing. In order to recover any unpaid reimbursement obligation of a Covered Person, the Trustees in their discretion may withhold, and apply to such obligation, benefits (whether or not related to the same claim) that otherwise become payable to the Covered Person or to any other Member of the group to

which the Covered Person belongs that consists of a Member of this Plan and the Member's Dependents.

(f) A Member is responsible for performing all obligations of a Covered Person who is the Member's eligible spouse or other eligible Dependent.

(g) The Plan specifically rejects the "make-whole" and "made-whole" doctrines and the collateral source rule. The Plan's rights to reimbursement and subrogation do not depend on whether the Covered Person recovers from third parties monies sufficient to fully compensate the Covered Person for all of his or her losses and they do not depend on how proceeds are captioned or characterized or whether the settlement or judgment identifies the benefits the Plan provided.

(h) If a Covered Person receives a third-party recovery in excess of benefits paid out at that time, and reimburses the Plan for all such benefits paid, and if additional benefits are claimed thereafter on account of the same Injury or Sickness, the Plan is not obligated to pay such additional benefits until the sum of all benefits paid and claimed for that Injury or Sickness exceeds the gross amount of the third-party recovery.

(i) If a Covered Person receives a third-party recovery that is less than benefits paid to that time, the plan may require an uninsured or underinsured motorist claim to be filed against the Covered Person's automobile insurance policy in order to satisfy the balance of the Covered Person's reimbursement obligation.

(j) The Plan's rights to recovery shall not be reduced due to the Covered Person's own negligence.

D. Duty to Notify and Cooperate with the Plan

1. A Covered Person shall promptly notify the Plan, in writing, of (i) any potential legal claim(s) against a third party for acts which caused an Injury or Sickness which Benefits are payable or have been paid under the Plan, and (ii) any recovery obtained from a third party, whether by judgment, settlement, arbitration or otherwise.
2. Upon retaining an attorney in connection with a third-party claim, the Covered Person must promptly notify the Plan of the name, address and telephone number of the attorney, and must inform the attorney that the Plan's rights of subrogation and reimbursement are not subject to any decrease for attorney's fees.
3. If the Trustees decide to advance benefits for an Injury or Sickness for which a third party may be or is liable, the Plan may require at any time, as a condition of commencing or continuing to pay benefits, the Covered Person and/or the Member (if the Member is not the Covered Person) sign a written agreement which may contain a confirmation of the reimbursement obligations of the Covered Person, an assignment to the Plan of any third-party recovery received, a confirmation of the lien of the Plan on such recovery, or other terms satisfactory to the Plan. If the Covered Person is represented by an attorney, the Plan may require the attorney to sign the subrogation and reimbursement agreement to signify that the attorney accepts and will comply with the Plan's subrogation and reimbursement provisions. However, the Plan's rights are not dependent upon any such agreement.
4. A Covered Person is obligated to take all actions reasonable in the circumstances to prosecute a claim against a third party who may be or is liable for an Injury or Sickness covered by the Plan.
5. A Covered Person must inform the Plan promptly, in writing, of any notice given to any party of any intention to pursue or investigate a claim to recover damages due to Injury or Sickness, or any claim which he or she asserts against a third party on account of an Injury or Sickness for which benefits are paid or payable, and furnish to the Plan the name and address of the third party, the name of the third party's

insurance company and attorney, if any, the basis of the claim, and any other relevant information requested by the Plan. In addition, in the case of injuries caused by a third party as the result of an automobile accident, a Covered Person must also furnish to the Plan the name, address and policy number of the Covered Person's automobile insurance company.

6. A Covered Person shall cooperate with the Plan and do whatever is necessary to secure the rights of the Plan, including, without limitation,
   (a) timely execution of all necessary forms, including, without limitation, an acknowledgement of the Plan's rights to reimbursement or subrogation and an assignment of claims or causes of action against each third party,
   (b) providing any relevant information requested by the Plan,
   (c) timely responding to requests for information about any accident, injury or illness, and
   (d) obtaining the Plan's comment before releasing any party from liability or payment of medical expenses or accepting any settlement that does not fully reimburse the Plan without its prior approval.

   The Covered Person shall do nothing to prejudice the Plan's rights of subrogation and reimbursement.
7. In the event a Covered Person refuses to accept a settlement offer for a third-party claim unless the Plan waives any of its rights under this Section X, the Plan is released from its obligation to pay benefits to the extent of the refused offer.
8. In the event the Plan has declined to advance benefits under the provisions of this Section X for an Injury or Sickness for which a third party may be or is liable, and the Covered Person and his or her attorney have complied with their obligations under this Section X, and it is established to the satisfaction of the Trustees, in the exercise of their discretion, that no third-party recovery can be had, or that a third-party recovery cannot be had in an amount at least equal to the benefits withheld, then in such event the Plan shall pay the withheld benefits reduced by the amount of any third-party recovery achieved.

E. Right of Offset and Recovery

The Trustees reserve the right to stop the advance of benefits and to recover any benefits previously advanced in the event:

1. The Covered Person or his or her attorney if any, fails to fully comply with the provisions of this Section X; or
2. The Trustees, in the exercise of their discretion, determine there is a likelihood the Covered Person or his or her attorney if any, will fail to fully comply with the Subrogation and Reimbursement provisions of this Plan.

In either such event, the Trustees have the right to offset and recoup the benefits previously advanced by withholding benefits (whether or not related to the same claim) that otherwise become payable to the Covered Person or to any other Member of the group to which the Covered Person belongs that consists of a Member and his or her eligible Dependents. The Trustees may also bring legal action against the Member and the Covered Person on whose behalf the benefits were advanced. If the Trustees find it necessary to file suit to recover the benefits advanced, and they prevail in such proceeding, both the Member and the Covered Person on whose behalf the benefits were advanced will be responsible for paying the Trustees' reasonable attorney's fees and costs. Any ERISA reimbursement lawsuit arising from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

Section XI

General Information about the Plan

This is the Plan Document governing the Plan. A copy of this Plan Document is available to any Member for viewing at the Plan Office. In addition, Members may obtain a copy of the Plan Document from the Plan Office at 1419 Hampton Avenue, St. Louis, Missouri 63139, by paying the Plan's charge for copying.

1. The name of the Plan is the St. Louis - Kansas City Carpenters Regional Health Plan.
2. The Plan Sponsor and Plan Administrator are the Board of Trustees of St. Louis - Kansas City Carpenters Regional Health Plan.
3. The Plan Address and Contact Information are:

   St. Louis – Kansas City Carpenters Regional Health Plan
   1419 Hampton Avenue
   St. Louis, Missouri 63139
   Telephone: (314) 644-4802
   Toll Free: (877) 232-3863
   benefits@carpdc.org

4. The Plan is a Welfare Plan providing benefits for Medical care, Prescription Drugs, Dental care, Vision care, Short-Term Disability, Life, Accidental Death and Dismemberment, and Safety Enhancement.
5. The Trustees have exclusive discretionary authority to determine eligibility for benefits, to construe the terms of the Plan, and to make all other determinations as to whether any particular individual is entitled to receive any benefit. Benefit determinations of the Trustees shall receive the maximum deference permitted by law.
6. The Trustees may debar a Provider of services or supplies, if the Trustees determine in their discretion that a Provider has:

   (a) Submitted false or fraudulent claims; or

   (b) Failed to comply with the terms of its contract with a Network engaged by the Plan; or

   (c) Repeatedly submitted claims in a manner that results in harassment or unreasonable administrative efforts in processing the Fund.

   No benefits will be due or paid by the Plan for services or supplies obtained from a debarred Provider during the period of debarment, which may be temporary or permanent.
7. The Plan is established and maintained pursuant to Collective Bargaining Agreements and participation agreements between Employers and the St. Louis - Kansas City Carpenters Regional Council. Contributions are made to the Fund by participating Employers for active Members. The Plan permits self-payments by underemployed, retired, disabled, and Self-Employed Members and Surviving Spouses, as well as COBRA continuation Premiums.
8. The Trustees have discretionary authority to contract with third parties to furnish any services and supplies the Trustees believe are advantageous to the Plan and its Members and Dependents, such as, but not limited to, insurers of certain benefits, Networks of Providers of medical, dental, vision, or other covered services, Networks of prescription drug Providers, claims adjudication, case management, and administrative services.

Section XII

Plan Definitions

Unless indicated otherwise in a specific context, words used in this booklet shall have the meanings set forth in this Section XII. Please note there are other definitions set out in the body of this booklet. Whenever required by the context of any plan provision, the masculine includes the feminine; the feminine includes the masculine, the singular the plural, and the plural the singular. Any headings used in the booklet are included for reference only and are not to be construed so as to alter any of the terms of the Plan.

1. **"Abortion"** means the termination of Pregnancy before the fetus reaches the stage of viability.
2. **"Active Classification"** as defined in Section I.C.1.
3. **"Active Work"** means the performance of work as an Eligible Member at such place as is required in the course of his employment.
2. **"Acute"** refers to an illness or Injury that is both severe and of recent onset.
4. "**Allied Health Professionals**" means Nurse Practitioners (NP), Certified Registered Nurse Anesthetists (CRNA), Physician Assistants (PA) and Certified Nurse Midwives (CNM) with respect to the services of such Providers specifically covered by the Plan and to the extent that such services are within the scope of the Provider's legally authorized practice and rendered under the direction of a Physician.
5. **"Allowable Amount"** as defined in Section II.B.
6. **"Alternate Facility"** is a non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis, or Mental Health or Substance Abuse services on an inpatient or outpatient basis, pursuant to the law of the jurisdiction in which treatment is received, including without limitation:
   (a) Scheduled surgical services
   (b) Emergency Health Services
   (c) Urgent Care Services, or prescheduled rehabilitative services
   (d) Laboratory or diagnostic services
7. **"Alternate Recipient"** is the child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.
8. **"Ancillary Service"** are those services not performed by an MD or DO and usually associated with, but not limited to lab, x-ray, nursing, dietary, pharmacy and rehabilitative services.
9. **"Appeal"** is a request by you or your Authorized Representative for consideration of an Adverse Benefit Determination of a Health Service request or benefit you believe you are entitled to receive or have coverage for.
10. **"Benefit Quarter"** means any of the three-month periods beginning January 1, April 1, July 1, and October 1 of each year.
11. **"Capped Credit Hour"** means credit hours received for a Member employed in work covered by a Collective Bargaining Agreement requiring contributions to this Fund for hours worked and for reasons other than hours worked, up to a maximum per month as expressly provided under the journeyman level of the applicable Collective Bargaining Agreement.
12. **"Carpenters' Pension Plans"** refers to the Pension Plan of the Carpenters' Pension Trust Fund of St. Louis, the Carpenters' Pension Trust Fund of Kansas City, Kansas City Open-End Building Trades Fund or the Carpenters Pension Fund of Illinois (Geneva).

13. **"Carpenters Regional Council (CRC) Employees"** as defined in Section I.A.2.
14. "**Child**" as defined in Section I.D.3.
15. **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.
16. **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.
17. **"Coinsurance"** is the percentage amount you must pay for a service or supply as defined by the benefit schedule.
18. **"Collective Bargaining Agreement"** is the written legal ***contract*** between the St. Louis – Kansas City Carpenters Regional Council and an employer.
19. **"Collectively Bargained Employees"** means the employees covered under the requirements of a Collective Bargaining Agreement.
20. **"Contribution Quarter"** means any of the three-month periods beginning February 1, May 1, August 1, and November 1 of each year.
21. **"Copayment"** or **"Copay"** is a specified fixed dollar amount you must pay as a condition of the receipt of certain services as provided in the Plan.
22. **"Covered Charge"** or **"Covered Expense"** means only the expense incurred, or portion of such expense determined to be allowable after application of the appropriate discount, if any, for medical care, services or supplies that:
    (a) are prescribed by a Physician and are necessary in connection with the therapeutic treatment of the Injury or Sickness involved,
    (b) are listed as Covered Charges and are not excluded from payment of benefits by the Exclusions and Limitations of the Plan,
    (c) are recognized as generally accepted medical practice, and
    (d) are not in excess of reasonable and customary charges for the same or similar medical care, services, and supplies.
23. **"Covered Individual"** or **"Covered Person"** means only a Member or a Member's Eligible Dependent who is eligible for benefits under the Plan in accordance with the Eligibility Section of this document.
24. **"Credit Hour"** means all the following:
    (a) Each hour for which a Member is directly or indirectly paid by a Member's Employer for which contributions are due have been made by the Employer and received by the Trust Fund.
    (b) Each hour for which a Member is directly or indirectly entitled to payment by a Member's Employer for which contributions are due but not paid, yet for which satisfactory proof a Member (excluding a Member in Non-Bargained Office Employee group) is entitled to payment of said Employer contributions, the number of such hours (if any) the Trustees in their discretion determine should in fairness be awarded to such Member for purposes of this Plan, but such award may be made only in unusual circumstances and only if the Trustees believe it is very likely that payment for the hours awarded will be received by the Trust Fund within a reasonable time.
25. **"Deductible"** refers to the amount of money a Member will need to pay before the Plan will start paying benefits on claims incurred.
26. **"Developmental Therapy"** means therapy designed to further growth or bring about improvement by gradual training adapted to the Covered Person's physical and mental development.
27. **"Durable Medical Equipment"** means equipment that meets all the following conditions:

(a) It can withstand repeated use.

(b) It is primarily and customarily used in the therapeutic treatment of Sickness or Injury.

(c) It is generally not useful to a person in the absence of a Sickness or Injury.

(d) It is appropriate for use in the home.

(e) It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.

(f) It is not primarily for the convenience of the person caring for the patient.

(g) It is not used for exercise or training.

(h) It is made and used externally to the human body for the therapeutic treatment of an Injury or Sickness.

28. **"Eligibility Class"** means the category or class which a Covered Person becomes qualified and maintains coverage.
29. **"Eligible for Medicare"** means an individual is eligible to enroll and participate in the Medicare program by reason of attained age and/or entitlement to Social Security benefits.
30. **"Emergency"** means an illness, injury, symptom or condition severe enough (including severe pain), that if the patient did not get immediate medical attention it would be reasonable to expect one of the following to result: 1) The patient's health would be put in serious danger; or 2) The patient would have serious problems with bodily functions; or 3) The patient would have serious damage to any part or organ of the patient's body.
31. **"Employer"** means Employer as defined in the Carpenters' Health and Welfare Trust Fund Agreement.
32. **"Enrollment Form"** is the required application for enrollment in the Plan.
33. **"Entitled to Medicare"** means an individual is both Eligible for Medicare and enrolled in any part of Medicare.
34. "**ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.
35. **"Experimental or Investigative"** means in connection with a drug, device, treatment, or procedure that:

(a) with respect to the illness being treated, the drug, device, treatment, or procedure cannot be lawfully marketed in the U.S. or has not been approved by the U.S. Food and Drug Administration (FDA) at the time the drug or device is furnished; or

(b) with respect to the illness being treated, the drug or device used in conjunction with a procedure not considered to be the standard of care; or

(c) with respect to the illness being treated, the drug, device, treatment or procedure, or the patient informed consent document used with the drug, device, treatment, or procedure, requires review and approval by the treating facility's Institutional Review Board or other body serving a similar function, or if U.S. federal law requires such review and approval; or

(d) with respect to the illness being treated, reliable evidence shows the prevailing opinion among experts in the appropriate field regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

1) Reliable evidence means only published reports and articles in medical and scientific literature including the opinions of the FDA, Council of Medical Specialty Services (CMSS), National Institute of Health (NIH) and Mental Health (NIMH), Office of Health Technology Assessment (OHTA), American Medical Association (AMA), American Dental Association (ADA) or Clinical Efficacy Assessment Program (CEAP); the written protocol(s) used by the treating facility or another facility

studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

2) For purposes of this Plan, clinical trials expressly covered under the Medical Benefit are not considered experimental or investigative.

36. **"Home Health Agency"** means a public or private agency or organization, or subdivision thereof, that:
    (a) is primarily engaged in providing skilled nursing and other therapeutic services,
    (b) has policies established by associated professional personnel, including one or more Physicians and one or more registered nurses (RN), to govern the services provided under the supervision of such a Physician or nurse,
    (c) maintains medical records on all patients, and
    (d) in cases where applicable state or local law provides for licensing of agencies or organizations of this nature, the latter are licensed or approved by the state or local law as meeting the standards established for such licensing.
37. **"Hospice Agency"** means a public or private agency or organization that administers and provides hospice care and is either:
    (a) licensed or certified as such by the state in which it is located,
    (b) certified (or is qualified and could be certified) to participate as such under Medicare,
    (c) accredited as such by the Joint Commission on the Accreditation of Health Care Organizations, or
    (d) in compliance with the standards established by the National Hospice Organization.
38. **"Hospice Care Program"** means a coordinated, interdisciplinary program to meet the physical, psychological, and social needs of terminally ill persons (life expectancy of six months or less) and their families by providing palliative (pain controlling) and supportive medical, nursing, and other health services through home or inpatient care during the Sickness or bereavement.
39. **"Hospital"** means a legally operated institution that meets one of the following requirements:
    (a) It is accredited as a Hospital by the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations, is supervised by a staff of Physicians and provides 24-hour-a-day nursing service and it is primarily engaged in providing either:
        1) general inpatient care and treatment of Sickness or Injury through medical, diagnostic, and major surgical facilities on its premises, or
        2) specialized treatment for mental and nervous disorders.
    (b) It is an approved nonresidential chemical dependency treatment center licensed by the jurisdiction (state, District of Columbia, territory, or possession of the United States, or province of Canada) in which it is domiciled and is providing outpatient treatment to a Covered Individual.
40. **"Illegal Activity"** is any felony or misdemeanor, or any other activity which is against civil or criminal law for which the Member was charged or arrested and is expected to be convicted.
41. **"Infertility Services"** means those Health Services designed for the primary purpose of successfully fostering and achieving conception and Pregnancy.
42. **"Injectable"** medication is prescription medications injected by or under the direct supervision of a Physician.

43. **"Injury"** means a non-occupational bodily Injury caused directly and exclusively by external means with respect to which benefits are not payable under any Workers' Compensation, occupational disease or similar law.
44. **"In-Network Provider"** or **"Network Provider"** means the Hospitals, Physicians, suppliers, ancillary Providers and other clinical facilities, pharmacies and vision care Providers who have a written agreement with the Network Sponsor to provide health care services and supplies to plan participants for a negotiated charge at the time the service or supply is provided. You may contact the Network at any time to determine a Provider's participation status. An In-Network Provider may be a regional Network or a national Network that the Plan has contracted with through a third party.
45. **"Maintenance Therapy"** is rehabilitative services and associated expenses designed primarily to be long-term with no significant medical improvement to the patient as determined by the Provider or Medical Director.
46. **"Managed Mental Health and Substance Abuse Network"** means the organization with whom the Plan has contracted to administer the Managed Mental Health Care program.
47. **"Medical Care Management"** means the services provided by the Plan to assist Members and their families to receive medical care, services, and supplies in the event of a catastrophic Sickness or Injury.
48. **"Medical Care Management Company"** means the organization with whom the Plan has contracted to administer the Managed Care program.
49. **"Medically Necessary" or "Medical Necessity"** means those services, supplies, equipment, and facility charges that are not expressly excluded under the Plan and are determined to the Plan to be:
    (a) Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks.
    (b) Necessary to meet health needs, improve physiological function and required for a reason other than improving appearance.
    (c) Rendered in the most cost-efficient manner and setting appropriate for the delivery of the Health Service.
    (d) Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested.
    (e) Consistent with the diagnosis of the condition at issue.
    (f) Required for reasons other than the comfort of the Covered Individual or the comfort and convenience of the Physician.
    (g) Not Experimental or Investigational as determined by the Plan.
50. **"Medicare"** means the federal program of Health Insurance for the Aged and Disabled (Part A and Part B), otherwise referred to as Title XVIII of the Social Security Act.
51. **"Member"** means an individual eligible for benefits, who is not covered solely as a dependent, and whose eligibility for benefits results from employment or former employment which Employer contributions were made to the Plan on behalf of such individual.
52. **"Network Sponsor"** means a provider network the Plan has contracted with to provide access to their provider network services and for other administrative services such as utilization review.
53. **"Non-Active Classification"** as defined in Section I.C.2.

54. **"Non-Bargained Office Employee"** means any employee of a contributing Employer who executes a Participation Agreement for Non-Bargained Office Employees and is accepted by the Trustees other than:
    (a) An employee covered by a collective bargaining agreement requiring contributions to this plan or another health and welfare plan, or
    (b) Partner or sole proprietor of the Employer and any other person who is prohibited by law from participating in this plan.
55. **"Non-Pension Member"** means a Member who is not eligible to participate in the Carpenters' Pension Plan but is eligible to participate in the Health and Welfare Plan due to a specific agreement with the St. Louis – Kansas City Carpenters Regional Council, like a participation agreement or a collective bargaining agreement.
56. **"Occupational Therapy"** means the use of work-related skills to treat or train the Covered Individual, to prevent disability, and to restore the Covered Individual to health, social or economic independence.
57. **"Open Enrollment"** means the time or times during the year when an employee may normally enroll for coverage in an Employer-sponsored health plan.
58. **"Out-of-Network"** or **"Non-Network Provider"** means a health care provider who is not contracted with one of the Plan's Network Sponsors.
59. **"Out-of-Pocket Maximum"** is the maximum amount Members will pay; once the Out-of-Pocket Maximum has been reached, the Plan will pay 100% of Covered Expenses for the remainder of the calendar year.
60. **"Part-Time"** is defined as an employee who on average works less than 30 hours per week.
61. **"Pharmacy Benefit Manager and Network Sponsor"** means the organization with whom the Plan has contracted with to administer the Prescription Drug Program.
62. **"Physical Therapy"** means the rehabilitation concerned with restoration of function and prevention of disability following Sickness or Injury. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet and massage are used to improve circulation, strengthen muscles, encourage return of motion and retrain an individual to perform the activities of daily living.
63. **"Physician"** means only a legally qualified doctor of medicine (MD), or doctor of osteopathy (DO). The term "Physician" also includes a licensed clinical psychologist, a licensed doctor of chiropractic (DC), a doctor of podiatric medicine (DPM), a doctor of dental surgery (DDS), a licensed doctor of medical dentistry (DMD) and a licensed doctor of optometry (OD), with respect to the services of such Providers specifically covered by the Plan and to the extent that such services are within the scope of the Provider's legally authorized practice.
64. "**Plan**" means the St. Louis - Kansas City Carpenters Regional Health Plan, which comprises the plan of benefits set forth herein whereby the assets of the Trust are to be used to provide Health and Welfare benefits to Participants.
65. **"Plan Year"** shall commence on May 1 of one year and end on April 30 of the succeeding year.
66. **"Post-Service Claim"** is an Appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
67. **"Pregnancy"** means the state of being pregnant, childbirth, miscarriage, and any complications arising from any of these conditions.
68. **"Premium"** is the monthly fee required for certain classes of coverage under the Plan.
69. **"Pre-Service Claim"** is an Appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided or requires Prior Authorization.

70. **"Preventive"** means the services are defined under the Affordable Care Act (ACA) as those immunizations, screenings and other ancillary services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA) and the federal Centers for Disease Control (CDC).
71. **"Preventive Recommendations"** are defined in Appendix C.
72. **"Primary Care Physician" (PCP)** refers to a physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. Internal Medicine, Family Physician, OB-GYN, Pediatrician, Doctor of Osteopathy and General Medicine physicians are all considered Primary Care Physicians under the Plan.
73. **"Prior Authorization"** or **"Pre-Certification"** is the review and approval of requests for certain services and/or supplies. Services that require Prior Authorization or Precertification are reviewed by a team of medical professionals prior to receipt of such services and supplies to determine Medical Necessity of care and that services are the standard of care.
74. **"Provider"** means a Physician, Hospital, or other Provider of medical care, services, or supplies. All providers must be licensed to provide services within the scope of their license by the state in which the services are rendered.
75. **"Qualified Medical Child Support Order (QMCSO)"** means a Medical Child Support Order issued by a court of competent jurisdiction or through an administrative process established under state law, which creates or recognizes the existence of an Alternate Recipient's right to receive benefit for which a member is eligible under the Plan in accordance with applicable state and federal laws.
    (a) A "Medical Child Support Order" is any judgment, decree, or order (including approval of a settlement agreement) which:
        1) provides for child support with respect to a member's child under the Plan or provides for health benefit coverage to such child, is made pursuant to a State domestic relations law (including community property law), and relates to benefits under the benefits Agreement; or
        2) is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.
76. **"Qualifying Event"** means "qualifying event" as defined in Section I.E.1.
77. **"Qualified Beneficiary"** means "qualified beneficiary" as defined in Section I.E.2.
78. **"Retired Member"** means a **"**retired member" as defined in Section I.C.2.(f).
79. **"Self-Employed"** for purposes under the Spousal Coverage Program means an individual, doing business as a sole-proprietor or partner, who either has no employees or offers no health coverage to employees.
80. **"Self-Injectable"** medication is medication that is injected by the patient or patient's caregiver.
81. **"Semi-private Accommodations"** is a room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is covered only when private accommodations are Medically Necessary or when Semi-private Accommodations are not available and when an exception has been made by the Medical Director in advance of the admission. Exceptions may or may not be granted by the Plan.
82. **"Sickness"** means a non-occupational bodily disorder, disease, mental infirmity, or Pregnancy with respect to which benefits are not payable under any Workers' Compensation, occupational disease, or similar law. All Sicknesses that are due to the same or related cause or causes will be deemed one Sickness.
83. **"Signatory Employers"** means an employer who is obligated by a Collective Bargaining Agreement to make Health and Welfare contributions to this Plan.

84. **"Skilled Nursing Facility"** means a legally operated institution that:
    (a) specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis and is certified by Medicare,
    (b) maintains on the premises, specialists in physical rehabilitation, skilled nursing, and medical care on an inpatient basis,
    (c) maintains on the premises all facilities necessary for medical treatment,
    (d) for a fee provides convalescents with room, board, and 24-hour skilled nursing care by one or more professional nurses and other nursing personnel needed to provide adequate medical care,
    (e) is under 24-hour supervision of a Physician or registered graduate nurse (RN),
    (f) keeps adequate daily medical records for each patient,
    (g) if not operated by a Physician, has the services of one available under an established agreement, and
    (h) is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, a facility for substance use disorder or a facility for Custodial Care, remedial education, or training.
85. **"Speech Therapy"** means the remediation or rehabilitation for speech and language impairments.
86. **"Spouse"** means "spouse" as defined in Section I.D.2.
87. **"Spousal Coverage Program"** is a plan provision that requires a spouse, who has access to their Employer-based health coverage, to enroll in that coverage in order to be covered under this Plan as secondary.
88. **"Total Disability"** means complete inability of the Member to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Member to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. The disability must require regular care and attendance by a Physician who is someone other than an immediate family Member.
89. **"Totally and Permanently Disabled"** means a Member who is permanently and totally disabled and cannot engage in any substantial gainful activity because of a physical or mental condition and a physician determines that the disability has lasted or can be expected to last continuously for at least a year or can lead to death.
90. **"Trust Agreement"** shall mean the Carpenters' Health and Welfare Trust Fund Agreement of May 1, 1953, as Restated December 11, 1975 and as further amended from time to time.
91. **"Trust Fund"** or **"Fund"** means the Fund established under the Trust Agreement that will receive contributions and from which any amounts payable under the Plan are to be paid.
92. **"Trustees"** shall mean the Trustees under the Trust Agreement.
93. **"Uncapped Credit Hours"** means credit hours received for a member employed in work covered by a collective bargaining agreement or participation agreement requiring contributions to this Fund for all hours of work and for reasons other than hours worked.
94. **"Urgent Care Claim"** is an Appeal that must be reviewed under an expedited Appeal process because the application of non-Urgent Care Appeal time frames could seriously jeopardize: (a) the life or health of the Member; or (b) the Member's ability to regain maximum function. An Urgent Care Appeal also is an Appeal involving: (c) care that the treating Physician deems urgent in nature; or (d) a determination by the treating Physician that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of prudent layperson that possesses an average knowledge of health and medicine.

Section XIII

Miscellaneous Plan Provisions

1. **Information to be furnished** - Members and dependents shall provide the Benefit Office with such information and evidence and shall sign such documents, as may reasonably be requested from time to time, for the purpose of administration of the Plan. Each person entitled to benefits under the Plan must file at the Benefit Office, in writing, his Social Security number, his post office address and each change of post office address. Any communication, statement, or notice addressed to such person at his latest post office address as filed at the Benefit Office shall be binding on such person for all purposes of the Plan. The Trustees shall not be obliged to search for or to ascertain the whereabouts of any such person.

2. **Limitation of Rights** - Neither the establishment of the Plan, any amendment to the Plan, nor the payment of any benefits, will be construed as giving to any Member, dependent or other person any legal or equitable right against the Trust or any Employer, except as provided herein. This Plan shall not be deemed to constitute a contract between an Employer and any Member, or to provide any Member with a right to continued employment.

3. **No Guarantee of Tax Consequences** - Notwithstanding anything in this Plan Document to the contrary, the Trustees neither ensure nor make any commitment or guarantee that any amounts paid to or for a Member or dependent pursuant to the Plan will be excludable from the Member's gross income or wages for federal, state or local tax purposes.

4. **Facility of Payment** - If any person entitled to payments under this Plan shall be under a legal disability or, in the sole judgment of the Trustees, shall otherwise be unable to apply such payments to his own best interest and advantage, the Trustees, in their discretion, may direct such payments to be made:

   (a) To his court-appointed guardian or conservator, or

   (b) To his spouse, another Member of his family or to any other person, to be expended for his benefit, or

   (c) To an adult person designated by the Trustees as a custodian for him under the Missouri Transfers to Minors Law or similar statute, or

   (d) To an adult person designated by the Trustees as a personal custodian for him under the Missouri Personal Custodian Law or similar statute.

   Any payment made by the Plan in accordance with the above provisions shall fully discharge the Plan to the extent of such payments.

5. **Severability of Provisions** - The provisions of this Plan are severable, and should any provision be ruled illegal, unenforceable, or void, all other provisions not so ruled shall remain in full force and effect.

6. **Physical Exam and Autopsy** - The Trustees shall have the right and opportunity to examine the person with respect to whom benefits are claimed when and so often as they may reasonably require during pendency of claims hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

7. **Legal Actions** - No action at law or in equity shall be brought to recover any benefit or payment under the Plan prior to the claimant's exhaustion of the claims and Appeals procedures set out in this Plan Document or until the Plan has failed to finally determine a claim within the time limits established for such determination, nor shall such action be brought at all with respect to uninsured benefits unless brought within two years from the earlier of the date the Trustees notified the claimant of their decision on Appeal or the date upon which such notification was due from the Trustees.

8. **Not Workers' Compensation Insurance** - The coverage provided by this Plan is not in lieu of and does not affect any requirements of coverage by Workers' Compensation Insurance.

9. **Rules of Construction** - The terms and provisions of this Plan shall be construed so as to bring the Plan into conformity with the Internal Revenue Code, ERISA and other governing federal law. The Plan shall be deemed to contain the provisions necessary to comply with such laws. If any provision of this Plan shall be held illegal or invalid, the remaining provisions of this Plan shall be construed as if such provision had never been included. This restated Plan Document supersedes any and all prior Plan Documents.

10. **Right of Offset and Recovery** - If this Plan erroneously pays or overpays benefits to or for any person, the Trustees reserve the right to recover such erroneously paid amounts from any person or organization to whom or on whose behalf the benefits were erroneously paid. In addition, the Trustees have the right to offset the erroneous payment by reducing future benefits due either to the person on whose behalf the payment was made, or to any other individual in the group consisting of a Member and the Member's Dependents to which that person belongs. The Trustees may also bring a legal action against the person on whose behalf the payment was made and the Member related to such person. If the Trustees institute legal proceedings to collect erroneously paid benefits, and they prevail in such proceedings, both the person on whose behalf the benefits were paid and the related Member will be responsible for paying the Trustees; reasonable attorney's fees and costs. Section X contains additional provisions relating to the Trustees' rights of offset and recovery in the case of failure to reimburse benefits advanced when such reimbursement is due.

11. **Amendment or Termination** - The Trustees reserve the right to amend or terminate this Plan at any time and in any manner, subject to the terms of any collective bargaining agreement or insurance policy pursuant to which plan benefits are provided. In the event of a termination of the Trust, all liabilities of the Plan shall be satisfied to the extent and as provided by the Trust Agreement, insurance policy or other agreement with an insurer, third party administrator or other entity, and any applicable law, provided, however, that any Plan amendment or termination may be limited by the terms of any insurance policy or agreement with a third party underlying or Funding a benefit of this Plan.

    Amendments to the Plan shall be adopted by action of the Trustees at a regular or special meeting of the Trustees, and shall be recorded in the minutes of such meeting, or in a formal document executed by the Trustees as an amendment to the Plan documents.

    Any such amendment to the Plan shall become effective upon adoption, or if a different effective date is specified by the Trustees, on such specified date.

    If an amendment to the Plan is recorded in minutes of the meeting at which it is adopted, the amendment shall be given effect as recorded in the minutes. If such amendment to the Plan is thereafter incorporated in a formal document executed by the Trustees as an amendment to the Plan document, the provisions of the formal document shall, upon execution, supersede the provisions of the meeting minutes with respect to such amendment to the Plan.

12. **Examination of Records** – Subject to any restrictions imposed by law, the Plan Administrator will make available to each individual covered by this Plan such records of the Plan as pertain to him and as he is legally entitled to examine, for examination at reasonable times during normal business hours.

13. **Reliance on Other Information** - In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, the insurers or administrators of any of the benefits offered within the Plan, or by accountants, counsel or other professional advisers or experts employed or engaged by the Trustees.

14. **Nondiscriminatory Exercise of Authority** - Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall take reasonable efforts to exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

15. **Source of Contributions** - Contributions to the Plan shall be made to the Trust Fund in accordance with the Carpenters' Health and Welfare Trust Fund Agreement and relevant collective bargaining agreements or other participation agreements.

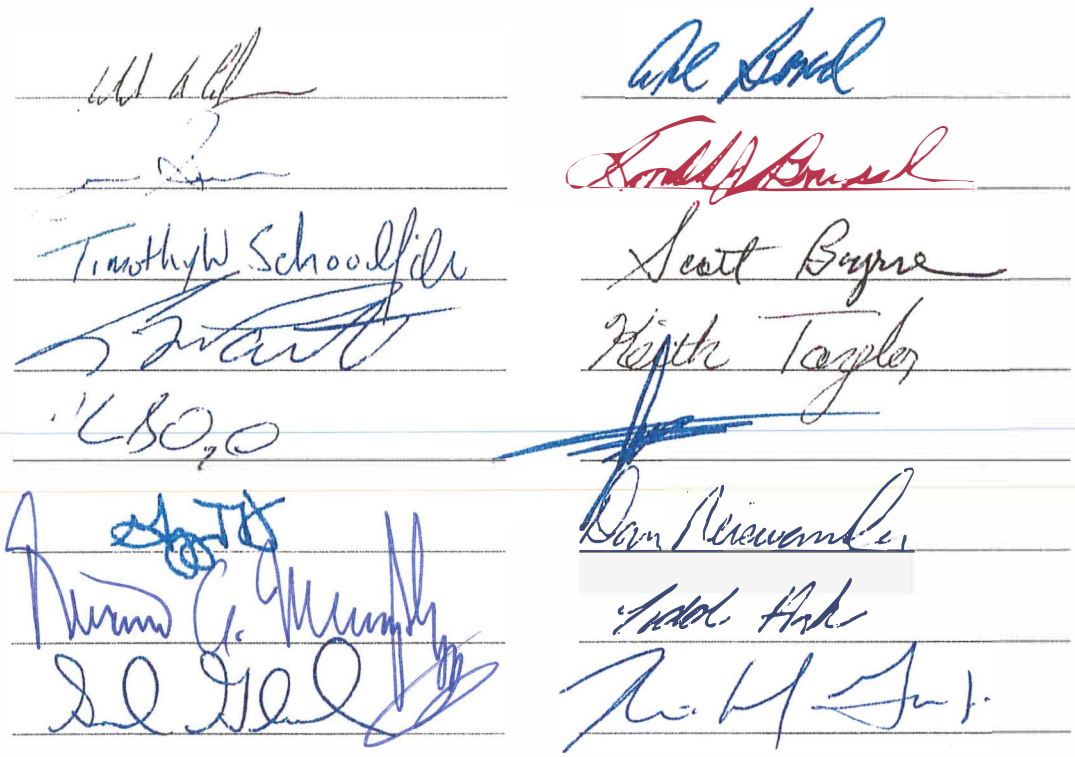
16. **Named Fiduciary –** The Plan's named fiduciary is the Board of Trustees, with power to appoint investment managers, and any person or entity designated by the Board of Trustees in writing as a named fiduciary of this Plan. Provided the Board of Trustees may revoke at any time the designation of any person or entity as a named fiduciary and may limit in any manner the authority of any named fiduciary to act on behalf of the Plan.

17. **Basis of Payments** - All Plan assets shall be used exclusively for the following:
    (a) Payment of Plan benefits to Covered Persons.
    (b) Defraying reasonable expenses incurred in connection with the administration of the Plan, including, but not limited to, administrative expenses and compensation and other expenses and charges of any legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator in connection with the administration of the Plan.
    (c) Payment of any insurance Premiums necessary for the Trustees to purchase risk protection on any portion of the Plan's benefit liability, as determined by the Trustees.
    (d) Payment of any tax, Premium or contribution required to remain in compliance with the Patient Protection and Affordable Care Act or other applicable law.

18. **Benefits are Not Vested –** No Covered Person, Provider, or any other person has a vested right to any Plan benefits or assets. The Trustees may, in their discretion, increase, reduce or eliminate any benefit at any time.

19. **Discretionary Authority** - The Board of Trustees has discretionary authority to determine a Claimant's eligibility for benefits and to interpret the terms of the Plan. Benefits under the Plan will be paid only if the Board of Trustees or its designee decides in its discretion that the Claimant is entitled to such benefits. The decision of the Board of Trustees or its designee shall be final and non-reviewable, unless found to be arbitrary and capricious by a court of competent review. Such decision will be binding upon the Board of Trustees and the Claimant.

IN WITNESS WHEREOF, the Board of Trustees of Carpenters' Health and Welfare Trust Fund of St. Louis does hereby adopt this Plan Document this 25th day of May, 2021.



All of the Trustees

Appendix A

Schedule of Medical Benefits

BENEFIT	Cigna Open Access Plus	Out-of-Network Providers
Annual Deductible – Member Responsibility	$200 Individual/$600 Family	$600 Individual/$1,800 Family
Annual Out-Of-Pocket Maximum – Member Responsibility	$2,000 Individual/$6,000 Family	$90,000 individual/Unlimited Family
Coinsurance – Member Responsibility	10%	50%
PREVENTIVE CARE		
Routine Preventive Care	Plan Pays 100% Member Pays 0%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Routine Mammogram	Plan Pays 100% Member Pays 0%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Routine Colonoscopy	Plan Pays 100% Member Pays 0%	Plan Pays 50% AFTER Member Pays Deductible & 50%
OFFICE VISITS – NON-ROUTINE		
Primary Care Physician Office Visit	Member Pays $25 copay	Plan Pays 50% AFTER Member Pays Deductible & 50%
Specialist Office Visit	Member Pays $50 copay	Plan Pays 50% AFTER Member Pays Deductible & 50%
Mental Health and Substance Abuse Office Visit Psychiatrists All other providers (including, but not limited to: Counselors, Social Workers, Psychologists)	Member Pays $50 copay Member Pays $25 copay	Plan Pays 50% AFTER Member Pays Deductible & 50% Plan Pays 50% AFTER Member Pays Deductible & 50%
Cigna Telehealth Connection Services Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones, and internet only when delivered by contracted medical telehealth providers (details on myCigna.com). No charge for Medical and Behavioral Telehealth. **Note:** Telehealth visits performed by a physician outside of Telehealth Connection Services are subject to the Primary/Specialty Office Visit copays stated above.	Member Pays $0 copay	Not Covered
OUTPATIENT SERVICES[1,3]		
Outpatient Surgery[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Active Members and Non-Medicare Retirees only Hearing Aid (Maximum $4,000 every 36 months)	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 90% AFTER Member Pays In-Network Deductible & 10%
Lab, Radiology, Anesthesia, Pathology, and other Ancillary Services	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
CT, PET, MRI Scans, Nuclear Scans and Other Diagnostic Services[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Physical, Speech and Occupational Therapy[3] All other therapies – Includes Cognitive Therapy and Pulmonary Rehabilitation[3]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%

BENEFIT	Cigna Open Access Plus	Out-of-Network Providers
Durable Medical Equipment, Orthotics and Prosthetics[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Breast Feeding Equipment and Supplies Limited to the rental of one breast pump per birth as ordered or prescribed by physicians. Includes related supplies.	Member Pays 0% coinsurance	Not Covered
Home Health Services/ Hospice[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Mental Health Substance Abuse Partial, Intensive Outpatient and Electroshock Treatment[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Chiropractic Care - Limited to 40 visits annually X-rays performed in office, as a part of Chiropractic care, are not subject to the deductible under Chiro benefit - for IN or OON. Co-insurance for In-network is 0%, no deductible and out-of-network is 50%, no deductible. Does not include Interpretation. Does not include Advanced Radiological Imaging.	Member Pays $10 Copay	No Deductible Member Pays 50% coinsurance
INPATIENT SERVICES[1]		
Inpatient Hospital Services[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Convalescent Skilled Nursing Facility[1] Aggregate 100-day maximum cross accumulates among all benefit levels	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Mental Health Substance Abuse Residential Care[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Observation Room[1]	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Physician Hospital Visits and Specialist Care/Consultations	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
Inpatient Ancillary Services (Emergency Room, Radiology, Anesthesiology, Pathology)	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 50% AFTER Member Pays Deductible & 50%
EMERGENCY AND URGENT CARE[2]		
Hospital Emergency Room[2]	Member Pays $250 Copay	Member Pays $250 Copay
Urgent Care Facility[4]	Member Pays $75 Copay	Plan Pays 50% AFTER Member Pays Deductible & 50%
Ambulance Service (Ground or Air)	Plan Pays 90% AFTER Member Pays Deductible & 10%	Plan Pays 90% AFTER Member Pays Deductible & 10%

[1]May require pre-certification through the Medical Care Management Company.

[2]In the event patient is admitted through the Emergency Room, the Emergency Room copay is waived and deductible/coinsurance applies. If an ER patient is not admitted as an inpatient, the Emergency Room copay is the only amount the Plan requires the patient to pay for all emergency services provided in the ER visit, regardless of whether any such services are billed separately or by a Non-Network Provider.

[3]Limited to combination of 60 visits annually.

[4]In an In-Network Urgent Care Facility, the copay is the only amount the Plan requires the patient to pay for all emergency services provided in the visit, regardless of whether any such services are billed separately or by a Non-Network Provider. The Plan's payment to a Non-Network Provider is limited to the Reasonable and Customary amount for the services.

Appendix B

Non-Preventive Services and Supplies

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Abortion	Abortion is covered only if the attending Physician certifies that carrying the fetus to term would directly endanger the life of the mother, or that the condition of the fetus is likely to result in death of the fetus during Pregnancy or within a few hours of delivery.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained. All elective Abortions are excluded except as stated.
Allergy Care	Allergy testing, diagnosis, treatment, allergy serum, administration of injections, and prescribed medications.	**Exclusions:** Services and supplies not administered by a Physician, such as, but not limited to, air filters, air purifiers, or air ventilation system cleaning.
Ambulance Service	Emergency ground medical transport services are covered only if all the following criteria are met: 1. The medical transport services comply with all local, state and federal laws and has all appropriate, valid licenses and permits; and 2. The ambulance has the necessary patient care equipment and supplies; and 3. The patient's condition is such that any other form of transportation is medically contraindicated; and 4. The patient is transported to the nearest Hospital with the appropriate facilities for treatment of the patient's illness or Injury or, in the case of an organ transplant, to the pre-authorized transplant facility. Emergency air or water medical transport service is an exceptional circumstance, covered only if all the above-stated criteria pertaining to ground transportation are met as well as any one or more of the following: 1. The patient's medical condition is such that the time needed to transport the patient by land poses a significant threat to the patient's health or life and requires immediate and rapid ambulance transport that could not be provided by land ambulance; or 2. The point of pickup is inaccessible to a land vehicle; or 3. Great distances, limited time frames, or other obstacles to land transport would prevent getting the patient to the nearest Hospital with appropriate facilities for treatment.	Prior Authorization is required for non-emergent transportation from one Hospital or medical facility to another. **Limitations:** Emergency air or water transport is covered only for the lowest cost aircraft or vessel available and appropriate for the patient's medical condition. **Exclusions:** All ambulance transportation services are excluded if the required criteria are not met.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Anesthesia	Anesthesia administered by a Physician or qualified Allied Health Professional.	**Exclusions:** Anesthesia in conjunction with non-covered medical or surgical procedures.
Assistant Surgeon	Services of an assistant surgeon who actively assists the primary surgeon, but only when the type of surgery requires assistance according to generally accepted medical practice.	**Limitations:** The Allowable Amount for services of an Assistant Surgeon reduced according to industry standards from the Allowable Amount for the services of the primary surgeon.
Blood and Blood Products	Administration, storage and processing of blood and blood products in connection with covered services and supplies.	**Exclusions:** Harvesting and storage of a patient's own blood, except for potential use in a covered, scheduled surgical procedure. Fetal cord blood harvesting and storage.
Brachytherapy	Brachytherapy treatment is covered.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Breast Reconstruction	Following a Medically Necessary mastectomy, breast reconstructive surgery and prosthesis are covered regardless whether Medically Necessary, including nipple reconstruction, augmentation or reduction of the affected breast, augmentation, or reduction of the opposite breast to restore symmetry, internal or external prosthesis, and lymphedema.	**Exclusions:** Reduction or augmentation mammoplasties that are not Medically Necessary and are unrelated to a Medically Necessary mastectomy.
Cardiac Diagnostic Testing	Cardiac diagnostic testing is covered when considered Medically Necessary when used to determine diagnosis. Examples of cardiac testing include angiography, cardiac catheterizations, radio frequency ablations, cardiac stress imaging and stress echocardiograms.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Cardiac Rehabilitation Therapy	Rehabilitation following cardiac surgery or disease to restore health as much as possible through exercise and education.	**Limitations:** 60 visits per calendar year.
Chemotherapy and Radiation Therapy	Standard chemotherapy and radiation therapy, including Intensity Modulated Radiation Therapy (IMRT), Stereotactic Radiation Therapy, Proton Beam Therapy, and dose-intensive chemotherapy.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Chiropractic Services	Chiropractic therapy within the scope of Provider's license, including initial diagnosis and supplies.	**Limitations:** Benefits are limited to 40 visits per calendar year per patient with no per visit or annual dollar limits.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Clinical Trials	Routine patient care incurred as a result of enrollment in Phase I, II, III or IV clinical trials undertaken for the purposes of the prevention, early detection, or treatment of cancer, if the clinical trial is conducted at an academic or NCI center and is approved or Funded by one the following entities: 1. National Institute of Health (NIH). 2. An NIH cooperative group or center. 3. The FDA in the form of an investigational new drug application. 4. The federal Departments of Veterans' Affairs or Defense. 5. A qualified research entity that meets the criteria for NIH Center support grant eligibility. 6. An institutional review board that has an appropriate assurance approved by the Department of Health and Human Services.	Prior Authorization required. **Exclusions:** Patient care for any clinical trial that does not meet the stated criteria; any non-health care services required in conjunction with the clinical trial (such as transportation, lodging, Custodial Care); services and supplies provided to enrollees in the clinical trial without charge; services required to conduct, manage and administer the clinical trial or to collect and analyze data; and supplies and services that would not be covered for reasons other than being Experimental or Investigative. Listed service or supply if required Prior Authorization was not obtained.
Cosmetic, Plastic and Related Reconstructive Surgery	Surgical correction of congenital birth defects or the effects of disease or Injury, provided that the surgery repairs defects resulting from an accident within one year of the accident or as soon thereafter as medically appropriate; replaces diseased tissue surgically removed, within one year of the surgery or as soon thereafter as medically appropriate; treats a birth defect in a Child as soon as medically appropriate; or is covered under the Plan's criteria for breast reconstruction following a covered mastectomy. Also see Breast Reconstruction.	Prior Authorization required. **Exclusions:** Services or supplies that are not obtained as soon as medically appropriate. Except as expressly listed, cosmetic or reconstructive procedures and any related services or supplies which alter appearance but do not restore or improve impaired physical function. Listed service or supply if Prior Authorization was not obtained.
Dental Services	Administration of general anesthesia in any facility, and Hospital charges, for dental care provided to the following Covered Persons only when authorized in advance by the Plan: 1. A Child under the age of five, or 2. A person who is severely disabled, or 3. A person who has a medical or behavioral condition which requires Hospitalization or general anesthesia when dental care is provided. Also see Oral Surgery.	Prior Authorization required. **Exclusions:** Except as provided in this list, the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery for impacted teeth, surgery involving structures directly supporting the teeth, dental implants or orthodontia, oral surgical procedures (including services for overbite or under bite, whether the services are considered to be medical or dental in nature, are not covered in the Medical Benefit. In addition, dental x-rays, supplies, and appliances (including occlusal splints and

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
		orthodontia), removal of dentigerous cysts, mandibular tori and odontoid cysts, and removal of teeth due to an Injury, prior to radiation or for radionecrosis, are also not covered in the Medical Benefit, but may be covered in the Plan's Dental Benefit. Listed service or supply if Prior Authorization was not obtained.
Dermatological Care	Removal of skin lesions, skin check-up and treatment of skin disorders when necessary to remove a skin lesion that interferes with normal body function or is suspected to be malignant, or skin tag removal.	**Exclusions:** All cosmetic procedures except as stated.
Diabetic Supplies	Plan approved glucose meters, insulin pumps and cartridges, and self-management training used in connection with the treatment of diabetes.	Prior Authorization required. **Exclusions:** Disposable insulin syringes, glucose strips, and lancets are not covered in the Medical Benefit, but may be covered under the Prescription Drug Benefit. Listed service or supply if Prior Authorization was not obtained.
Diagnostic and Treatment Services	The following services rendered by a Physician, whether in or out of the Physician's office: • Diagnosis and treatment of covered illness or Injury. • Administration of Injectable medication normally rendered in a Physician's office. • Consultations with specialists. • Performance of laboratory tests. Also see Laboratory Services.	
Dialysis	Hemodialysis and peritoneal services provided by outpatient or inpatient facilities, or at home only if patient is homebound. For home dialysis, equipment, supplies, and maintenance are covered.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Durable Medical Equipment (DME)	DME that is determined to be necessary and reasonable for the treatment of an illness or Injury, or to improve the functioning of a malformed body part, and when all the following circumstances apply: 1. It can withstand repeated use, 2. It is primarily and customarily used to serve a medical purpose, 3. It is generally not useful to a person in the absence of illness or Injury, 4. It is appropriate for use in the home, and 5. It does not exceed the minimum specifications that are Medically Necessary. Coverage is for rental if not expected to exceed the purchase price, or for purchase if rental is expected to exceed the price, of Durable Medical Equipment only when authorized in advance by the Plan and ordered by or provided by or under the direction of a Physician for use outside a Hospital or Skilled Nursing Facility. Covered equipment can include, but is not limited to, the following: wheelchairs; standard Hospital-type beds; continuous passive motion devices; initial purchase of elastic garments; oxygen and equipment for the administration of oxygen; mechanical equipment necessary for the treatment of chronic or Acute respiratory failure (ventilators and respirators); and insulin pumps.	Prior Authorization required. **Limitations:** Upgrades to equipment are not covered unless Medically Necessary due to change in the patient's condition. Replacement of purchased equipment that has become non-functional and non-repairable due to normal, routine wear and tear is covered only after five years from date of purchase, or the expected life if less, during which time the Covered Person has been continuously eligible for Plan benefits. **Exclusions:** Listed service or supply if Prior Authorization was not obtained. Equipment that does not satisfy all stated criteria or is superior to other alternatives primarily because of comfort or convenience, regardless whether prescribed by a Physician. Exercise equipment, air purifiers, central or unit air conditioners, humidifiers and dehumidifiers, allergenic pillows or mattresses and water beds are examples of excluded equipment.
Durable Medical Equipment Supplies	Non-disposable supplies needed for use of covered Durable Medical Equipment, except over-the-counter supplies. Supplies related to a TENS unit are only covered with the initial purchase of the TENS unit.	**Exclusions:** Over the counter supplies and all disposable supplies.
Emergency Services	Services and supplies furnished or required to screen and stabilize an Emergency medical condition, when provided on an outpatient basis at either a Hospital or an Alternate Facility.	**Exclusions:** No benefits are payable for non-Emergency services received in an Emergency Room or an Urgent Care Facility.
Enteral Tube Feeding	Enteral or parenteral nutrition.	Prior Authorization required. **Exclusions:** Nutritional support that is taken orally.
Eyeglasses and Corrective Lenses	The first pair of eyeglasses or corrective lenses following cataract surgery is covered by the Plan. Additional coverage may be available under the Vision Benefit.	**Exclusions**: No other coverage for eyeglasses and corrective lenses under the medical benefit is allowed.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Genetic Testing and Counseling	Genetic testing, counseling and studies for diagnosis or treatment of genetic abnormalities.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Hearing Aid Benefit	Hearing Examination, maximum once per year. Hearing Aid device, $4,000 maximum every three years. Payable at 90% coinsurance, subject to in-network deductible.	**Limitations:** Available only to Members in the Active classification and non-Medicare Retired Members. $4,000 maximum benefit, every three years.
Home Health Care Services	Home health care services delivered through a Home Health Agency only when all the following requirements are met: 1. Services which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist. 2. Services are a substitute or an alternative to Hospitalization. 3. Services are Part-Time and intermittent. 4. A treatment plan has been established and periodically reviewed by the ordering Physician. 5. Services were approved in the Plan's Prior Authorization procedures. 6. The agency rendering services is Medicare certified and licensed by the State of location. 7. The patient is homebound or confined in a custodial setting.	Prior Authorization required. **Limitations:** Home Health visits are limited to 100 visits per calendar year. A visit is defined as four or less hours. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Hospice	Hospice care rendered for treatment of a Covered Person through a Hospice Agency or Hospice Care Program with a prognosis of six (6) months or less to live. Includes supportive care involving the evaluation of the emotional, social, and environmental circumstance related to or resulting from the illness, and guidance and assistance during the illness for the purpose of preparing the patient and the patient's family for imminent death.	
Hyperbaric Oxygen Therapy (HBOT)	Hyperbaric Oxygen Therapy is covered.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Implants and Related Health Services	Implant devices and related implantation services including pacemakers, joint replacements, AEDs, implantable TENS units, spinal braces, penile implants (unless prescribed to treat impotence which is psychological in origin), and implants for the delivery of prescription medication. See also Preventive implants for contraception in Appendix C below.	Prior Authorization required, except contraceptive implants covered as Preventive. **Exclusions:** Listed service or supply if Prior Authorization was not obtained. Replacement of covered implants is not covered, except when Medically Necessary due to a change in the patient's condition.
Impotence	Treatment for male organic impotence.	**Limitations:** Treatment for male psychogenic impotence is covered only under the Mental Health benefit.
Infertility	Only diagnostic studies up to the point of an infertility diagnosis are covered.	Prior Authorization required. **Exclusions:** Treatment of infertility. Listed service or supply if Prior Authorization was not obtained.
Injectable medications	Injectable medications when FDA-approved for the patient's disease or condition and administered by an appropriately licensed medical professional.	**Exclusions:** Self-Injectable medications are excluded from the Medical Benefit and may be available under the Prescription Drug Benefit.
Inpatient Hospital Care	Semi-private Accommodations, Intensive Care Unit, or Coronary Care Unit, as appropriate; general nursing care; use of operating room, surgical and anesthesia services and supplies; blood and blood products; ordinary casts, splints and dressings; all drugs and oxygen used in the Hospital; laboratory and X-ray examinations; electrocardiograms. Consistent with the Plan's utilization management policy, all Acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay.	Prior Authorization required, except maternity admission for delivery and postpartum care first 48 hours after vaginal delivery or first 96 hours after cesarean section. **Limitations:** Medical Necessity is subject to continuous review. Coverage is for the lowest level of care that is Medically Necessary and will cease if inpatient care is no longer Medically Necessary. **Exclusions:** Personal comfort and convenience items or services during inpatient stay, such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies. Listed service or supply if Prior Authorization was not obtained.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Laboratory Services	Laboratory services within the standard of care for the particular diagnosis.	Prior Authorization required for genetic testing. **Limitations:** Coverage is limited to services that are less costly and likely to produce results equivalent to the prescribed services, when clinically appropriate. **Exclusions:** Laboratory services in excess of the standard of care, and laboratory services without Prior Authorization.
Mastectomy	Mastectomies are covered. Also see Breast Reconstruction.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Maternity Services	Maternity-related medical, Hospital and other covered services and supplies for the mother and her newborn Child, including up to forty-eight (48) hours of inpatient post-natal maternity care for vaginal delivery and ninety-six (96) hours of inpatient post-natal maternity care for cesarean delivery. If there is a shorter length of stay, post-discharge care is covered as follows: Up to two (2) visits, at least one (1) of which may be in the home, in accordance with maternal and neonatal physical assessments, by a Physician or a registered professional nurse with experience in maternal and child health nursing. Services of certified and licensed Mid-Wives are covered in the states in which they practice.	**Limitations:** Notification of the Plan by the patient, and Prior Authorization, required for an inpatient stay beyond 48 hours after vaginal delivery or 96 hours after a caesarian section delivery. **Exclusions:** Home delivery is excluded from the Plan.
Medical Complications	Complications arising from a covered surgical procedure.	Prior Authorization required. **Exclusions:** Complications resulting from failure to follow the prescribed course of treatment, and complications arising from a service or supply not covered by the Plan. Listed service or supply if Prior Authorization was not obtained.
Medical Services in a Physician's Office	See Office Visits.	

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Member Assistance Program (MAP)	Regardless whether Medically Necessary, confidential counseling services in the following areas are covered only if offered and obtained in the Plan's Member Assistance Program • Stress Management • Legal problems • Positive drug/alcohol test • Marital and family counseling • Parenting • Anxiety, depression, and grief	**Limitations:** Six (6) visits per episode. **Exclusion:** MAP services are available only through the Mercy Member Assistance Program which is a part of the Mercy Managed Behavioral Health Network. To obtain services through the MAP call 314-729-4600 or toll-free at 800-413-8008.
Mental Health and Substance Abuse Services (MHSA)	Services and supplies for diagnosis and treatment of mental health and substance abuse conditions are covered, subject to all limitations and restrictions of the Plan applicable to particular services and supplies. In-Network Providers for these services and supplies are limited to those Providers in the Plan's Mental Health and Substance Abuse Network.	Prior Authorization required for all facility services.
Newborn Inpatient Care After Discharge of Mother	Services and supplies otherwise covered are also covered, as applicable, for care of neonates. In addition, services and supplies for diagnosis and treatment of conditions unique to newborns are covered, subject to all limitations and restrictions of the Plan, including congenital defects, birth abnormalities, or prematurity, and transportation of the newborn to and from the nearest facility that is appropriately staffed and equipped to treat the newborn's condition.	Prior Authorization required. **Exclusions:** Transportation of newborn for health care unnecessary for appropriately staffed and equipped facility. Listed service or supply if Prior Authorization was not obtained.
Office Visits	Services and supplies are covered if appropriately provided during an office visits to a Physician, including but not limited to • Diagnosis and treatment of illness or Injury. • Injectable medication that requires supervision from a health care professional and is normally rendered in a Physician's office. • Consultations with Specialists.	**Exclusions:** Self-injectable medications.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Oral Surgery and Diseases of the Mouth	Services and supplies required for treatment of an Injury to the jaw as a result of an accident, provided treatment is received as soon as medically appropriate. Removal of tumors and cysts of the jaw, lips, cheeks, tongue, roof and floor of mouth, and removal of bony growths of the jaw, soft and hard palate. Service and supplies for oral surgery, limited to the reduction or manipulation of fractures of facial bones; excisions of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect. Diseases of the mouth, except dental disease or disease of dental origin. Diagnosis and surgical treatment for temporomandibular joint disorder (TMJ) and craniomandibular joint disorder. Non-surgical treatment of TMJ including evaluation, x-rays, removable non-orthodontic appliance, therapy, minor procedures for occlusal equilibration or adjustments, treatment of muscle spasms and injections. Also see Dental Services.	Prior Authorization required. **Exclusions:** Any listed service or supply for which Prior Authorization was not obtained. Dental diseases, and services and supplies covered in the Plan's Dental Benefit. Orthodontic treatment of TMJ, and orthodontic appliances for such treatment. Services and supplies required for treatment of an Injury to teeth as a result of an accident are excluded but may be covered under the Plan's Dental Benefit.
Orthotics for Feet	Custom made foot orthotics. Replacement orthotics are covered provided the replacement is prescribed by a Physician and Medically Necessary due to a change in the patient's physical condition.	Prior Authorization may be required. **Exclusions:** Over the counter orthotics or other inserts not custom made for the patient.
Outpatient Diagnostic Tests and Therapeutic Treatments	Prescheduled outpatient diagnostic tests and therapeutic treatments ordered by an attending Physician, performed at a Hospital or Alternate Facility, including but not limited to CT Scans, Pet Scans, Ultrasound, Echo Cardiogram, MRI and MRA, chemotherapy, and radiation therapy.	Prior Authorization is required for those diagnostic tests and therapeutic treatments so specified in a list maintained by the Plan, available by calling the Benefit Office. **Exclusions:** Listed service or supply if required Prior Authorization was not obtained.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Outpatient Surgery	Services and supplies for prescheduled outpatient surgery performed at a Hospital or Alternate Facility under the direction of an attending Physician.	Prior Authorization is required for those outpatient surgical procedures specified in a list maintained by the Plan, available by calling the Benefit Office. **Exclusions:** Listed service or supply if required Prior Authorization was not obtained. Experimental or Investigational surgical procedures or devices used as part of the surgery are not covered.
Pain Management	Pain management services and supplies, pain management injections (including epidural, trigger point and facet injections) are covered.	Prior Authorization required. **Exclusions:** Listed service or supply for which Prior Authorization was not obtained.
Phenylketonuria (PKU) or other Amino and Organic Acid Inherited Disease Formula and Food	Formula and low protein modified food products used for PKU or any other amino and organic acid inherited disease when prescribed by a Physician, conditioned on Prior Authorization.	Prior Authorization required. **Limitations:** Coverage is limited to children under the age of six (6). **Exclusions:** Listed service or supply for which Prior Authorization was not obtained.
Podiatry	Services of a podiatrist are covered, including without limitation, foot care obtained in connection with a diagnosis of diabetes such as clipping nails or treating corns, calluses.	**Exclusions:** Lithotripsy for treatment of plantar fasciitis is excluded. Over the counter inserts are excluded.
Pregnancy	Diagnosis and treatment of Pregnancy is covered on the same basis as any illness or Injury. See also Covered Preventive Care for Women Including Pregnant Women in Appendix C.	Prior Authorization required for a Hospital stay longer than 48 hours after vaginal delivery or 96 hours after cesarean section. Notification of Pregnancy in the first Trimester is recommended. **Exclusions:** Listed service or supply if required Prior Authorization was not obtained.
Preventive Services	See Appendix C	

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Prosthetic Devices and Braces	Prescribed prosthetics for initial replacement of a lost natural body part are covered, including, but not limited to, purchase of artificial limbs, breasts, and eyes, limited to the basic functional device which will restore the lost body function or part. For placements requiring a temporary, followed by a permanent, placement only one (1) device will be covered. Replacement of a prosthesis furnished by the Plan, except breast prosthesis, will be covered only if it becomes non-functional and non-repairable due to normal wear and tear, or is Medically Necessary due to a physical change on the part of the patient. For breast prosthetics, replacement will be covered if determined necessary by the patient's Physician. Splints and braces, other than dental braces, are covered, including necessary adjustments to shoes to accommodate leg braces. See also Orthotics for Feet.	Prior Authorization required for prosthetic devices over $10,000, and for refitting or replacements. **Exclusions:** Over-the-counter braces, splints, and prostheses. Listed service or supply if required Prior Authorization was not obtained.
Pulmonary Rehabilitation Therapy	Pulmonary rehabilitation therapy is covered.	**Limitations:** Per Appendix A Outpatient Services, all other therapies, including Cognitive Therapy and Pulmonary Rehabilitation Therapy, combined (In and Out of Network) Maximum of 60 Day(s) per calendar year.
Radiology	Radiology services and supplies are covered.	Prior Authorization is required for those radiology services and supplies specified in a list maintained by the Plan, available by calling the Benefit Office. **Exclusions:** Listed service or supply if required Prior Authorization was not obtained.
Reconstructive Surgery	See Breast Reconstruction and Cosmetic, Plastic and Reconstructive Surgery.	
Rehabilitation Services and Supplies Visits	Physical Therapy, Occupational Therapy, and Speech Therapy prescribed by attending Physician, and provided in an outpatient setting by a physical therapist or occupational therapist, and for Speech Therapy a speech pathologist, audiologist, or speech/language pathologist, within the scope of their respective licenses. See also Home Health Care Services for therapy administered in home or in a custodial setting.	**Limitations:** 60 visits per year, all listed types combined. **Exclusions:** Rehabilitative services provided for long-term, chronic medical conditions. Rehabilitative services whose primary goal or effect is to maintain patient's current level of function, as opposed to improving functional status.

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
		Educational or vocational therapy designed to retrain patient for employment. Rehabilitative services whose purpose is to improve a developmental or learning disability or delay. Alternative rehabilitation services such as, massage therapy. Services and supplies whose usual purpose is nontherapeutic exercise, including, but not limited to, health clubs, fitness centers, weight loss centers or clinics, and home exercise equipment.
Sclerotherapy	Treatment of varicose veins is covered.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Skilled Nursing Facility (SNF) Services	Confinement in SNF, together with medical services and supplies provided in the SNF, are covered only for care and treatment that cannot be safely or effectively provided in an outpatient setting, as determined by the Plan.	Prior Authorization required. **Limitations:** SNF confinement for maximum of 100 days per calendar year. Accommodations limited to semi-private. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Sleep Studies	Sleep studies to diagnose obstructive sleep apnea are covered.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Sterilization	Vasectomy is a covered procedure in an office setting. Tubal ligation is covered as a Preventive benefit; see Appendix C.	**Exclusions:** Reversal of sterilization is not covered.
Termination of Pregnancy	See Abortion.	
TMJ	See Oral Surgery.	

NON-PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Transplant Travel Benefits *Contact Cigna for more detailed information regarding the LifeSource Transplant Travel Program.	Travel Benefits are available only for an organ transplant Member and their Spouse or significant other and the living donor for lodging, meal charges and transportation to and from a facility for evaluation and transplant services if these conditions are met: 1. The Carpenters' Benefit Plan is the primary benefit payer; and 2. An approved facility within the transplant Network is used; and 3. The patient and living donor live greater than 50 miles one way from the approved facility; and 4. Transplant travel pertains to travel within the United States*. Air travel is recommended when Member and living donor live greater than 150 miles one-way from the approved facility. Airfare by common carrier and baggage fees not exceeding coach and economy are covered. The cost of gasoline will only be covered or reimbursed, as appropriate, and mileage will no longer be eligible for reimbursement. Reasonable expenses as determined by the Trustees are covered for parking, taxi, and shuttle buses.	Prior Authorization is required. **Limitations:** Total travel benefit per transplant of $10,000 includes the Member and living donor. Accumulation of benefits begins with the start date of the evaluation appointment with the transplant facility to 12 months following the discharge date from the transplant facility post-transplant. Lodging is limited to $50 per night, per person for up to two people (maximum $100 per night), including the transplant recipient. Amounts exceeding the limit are the member's responsibility. Air travel is limited to the transplant Member, plus one other person or for both parents if for child transplant Member.
Transplants (Organ) and Related Transplant Therapies	Services and supplies for organ transplants are covered only if obtained in the Plan's Transplant Network and are conditioned on Prior Authorization. Advanced cellular therapy, including, but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered only when performed at a Cigna LifeSOURCE Transplant Network® facility with a Cigna approved stem cell transplant program.	Prior Authorization required. **Exclusions:** Any transplant service by a Provider outside of the Transplant Network. Any advanced cellular therapy by a Provider outside of the approved Cigna LifeSOURCE Transplant Network®. Listed service or supply if Prior Authorization was not obtained.
Urgent Care Services	Urgent care services provided at an Alternate Facility such as an urgent care center are covered.	
Vision Therapy	Vision therapy is covered when Medically Necessary to treat convergence insufficiency.	**Limitations**: Only diagnosed convergence insufficiency is covered.

Appendix C

Preventive Services and Supplies

PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Covered Preventive Services for All Adults	**The services and supplies listed in this box, delivered to a Covered Person by a Physician as part of an annual Preventive exam, are covered under the Platinum Benefit Schedules to the extent and under the conditions specified in the Preventive Recommendations:** Abdominal Aortic Aneurysm - Once-in-Lifetime screening for men of specified ages who have ever smoked. Alcohol Misuse - Screening and Counseling. Aspirin (OTC) – Covered only under the Prescription Drug Benefit. Blood Pressure Screening. Cholesterol Screening - Screening for adults of specified ages or at higher risk. Colorectal Cancer Screening - Screening for adults over 50 years of age. Depression Screening. Type 2 Diabetes Screening - Screening for adults with high blood pressure. Diet counseling – for adults at higher risk for chronic disease. HIV Screening – for all adults at higher risk. Immunization – in specified doses, for specified ages and populations: • Hepatitis A – if a risk factor is present • Hepatitis B – if a risk factor is present • Herpes Zoster – for specified ages • Human Papillomavirus • Influenza (flu shot) • Measles, Mumps, Rubella – for adults born in or after 1957 who lack documentation of one or more doses of MMR • Meningococcal – for first year college students and patients with risk factors • Pneumococcal – over age 65, or if a risk factor is present • Tetanus, Diphtheria, Pertussis – for adults with unknown or incomplete history of prior vaccination • Varicella – for adults without evidence of immunity to varicella Lung cancer screening for certain adults age 55-80 with history of risk factors.	**Limitations:** A listed service or supply is covered once each calendar year, unless otherwise stated.

PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	Obesity Screening and counseling. Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk. Tobacco Use – Screening for all adults, and cessation interventions for tobacco users. Cessation coverage is limited to the Plan's approved program. Syphilis – Screening for all adults at higher risk.	
Additional Covered Preventive Services for Women, Including Pregnant Women	**The services listed in this box, delivered to a female Covered Person by a Physician as part of an annual Preventive exam are covered under the Benefit Schedules to the extent and under the conditions specified in the Preventive Recommendations:** Anemia – routine screening for pregnant women. Bacteriuria - urinary tract or other infection screening for pregnant women. BRCA counseling and genetic testing - for women at higher risk. Breast Cancer Mammography screenings – one baseline screening between ages 35-39, then every 1 – 2 years for women over 40. Breast Cancer Chemoprevention counseling and risk reducing medication without cost share for women at higher risk. Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Hospital grade breast pumps are covered only as required by Medical Necessity guidelines issued by the United States Preventive Task Force. Cervical Cancer - screening for sexually active women. Chlamydia Infection - screening for younger women and other women at higher risk. Contraception: Food and Drug Administration – approved contraceptive methods, sterilization procedures (tubal ligation) and patient education and counseling, Oral contraceptives and some implantable are covered only under the Prescription Drug Benefit. Domestic and interpersonal violence screening and counseling. Folate supplements for women who may become pregnant. Gestational diabetes screening - for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes.	**Limitations:** A listed service or supply is covered once each calendar year, unless otherwise stated.

PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	Gonorrhea screening - for all women at higher risk. Hepatitis B screening - for pregnant women at their first prenatal visit. Human Immunodeficiency Virus (HIV) - screening and counseling for sexually active women. Human Papillomavirus (HPV) DNA Test - high-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older. Osteoporosis screening - for women over age 60 with specified risk factors. Rh incompatibility screening - for all pregnant women and follow-up testing for women at higher risk. Tobacco Use - expanded counseling for pregnant tobacco users, in addition to benefits described above for all adults. Sexually Transmitted Infections (STI) - counseling for sexually active women. Syphilis screening - for all pregnant women or other women at increased risk. Well-woman office visits to obtain covered Preventive services.	
Covered Preventive Services for Children	**The services and supplies listed in this box, delivered to a Covered Person under the age of 19 unless otherwise stated, by a Physician as part of an annual Preventive exam are covered under the Benefit Schedules to the extent and under the conditions specified in the Preventive Recommendations:** Alcohol and Drug Use assessments for adolescents. Autism screening for children at 18 and 24 months. Behavioral assessments. Blood Pressure screening. Cervical Dysplasia screening for sexually active females. Congenital Hypothyroidism screening for newborns. Depression screening for adolescents. Developmental screening for children under age three, and surveillance through childhood. Dyslipidemia screening for children at higher risk of lipid disorders. Fluoride Chemoprevention supplements for children without fluoride in their water source – covered only under the Prescription Drug Benefit. Gonorrhea Preventive medication for the eyes of all newborns.	**Limitations:** A listed service or supply is covered once each calendar year, unless otherwise stated.

PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	Hearing screening for all newborns. Height, Weight and Body Mass Index measurements. Hematocrit or Hemoglobin screening. Hemoglobinopathies or sickle cell screening for newborns. HIV screening for adolescents at higher risk. Immunization in specified doses, for specified ages and populations: • Diphtheria, Tetanus, Pertussis • Haemophilus influenza type B • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza (flu shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Rotavirus • Varicella Iron supplements for children ages 6 to 12 months at risk for anemia. Lead screening for children at risk of exposure. Medical History of all children throughout development. Obesity screening and counseling. Oral Health risk assessment for young children. Phenylketonuria (PKU) screening for this genetic disorder in newborns. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk. Tuberculin testing for children at higher risk of tuberculosis. Vision screening.	

Appendix D

Medical Exclusions

1. Any service or supply not Medically Necessary for the treatment of a Sickness or Injury, or that exceeds in scope, duration, or intensity, that level of care needed to provide safe, adequate, and appropriate diagnosis or treatment, except those services and supplies expressly noted in Appendix C above as being covered regardless whether Medically Necessary.
2. Any service or supply that is not a covered service or supply, or that directly or indirectly results from receiving a non-covered service or supply.
3. Occupational or Work-Related Injury or Sickness, or any Injury or Sickness which the Covered Person may be entitled to or receives benefits under any applicable Workers' Compensation Act, Occupational Disease policy or similar law (including settlement of a claim).
4. Any service or supply provided by a close relative or a person who resides with the Covered Person.
5. Any treatment for a Sickness or Injury or other condition that is court-ordered or is a condition of probation or parole.
6. Any covered service or supply provided for a Covered Person's health condition after the Covered Person has failed to comply with or complete the covered course of treatment prescribed by a Provider for the same condition.
7. A service or supply rendered outside the scope of any Provider's license.
8. Acupuncture services and associated expenses of any kind, including, but not limited to, treatment of painful conditions or for anesthesia purposes.
9. Allergy Services – Non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.
10. Alternative Therapies – Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing.
11. Autopsy – Services and associated expenses related to the performance of autopsies.
12. Biofeedback.
13. Braces or supports needed solely for athletic participation or employment.
14. Charges over 12 months old from the incurred date when submitted for consideration to the Plan.
15. Christian Science Practitioners – Christian Science Practitioners' services, with the exception of Medicare certified Religious Non-Medical Health Care Institution services.
16. Cosmetic or reconstructive procedures and any related services or supplies which alter appearance but do not restore or improve impaired physical function, except as expressly listed in Appendix B under Cosmetic, Plastic and Related Reconstructive Surgeries.
17. Counseling – Services and treatment related to religious counseling, marital and relationship counseling, vocational or employment counseling and sex therapy, except as expressly listed in Appendix B or as provided in the Member Assistance Plan.
18. Custodial Care not rendered during a covered inpatient admission, including, but not limited to, non-medical domiciliary care, respite care, rest care, or similar services primarily assisting Covered Persons in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, using the toilet. Also excluded, except during a covered inpatient admission, are preparation of special diets, supervision of medication usually self-administered, and any health-related services except

covered Hospice that do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or that do not require continued administration by trained medical personnel.

19. Educational Services – Educational services for remedial education or Developmental Therapy.
20. Equipment or services for use in altering air quality or temperature.
21. Elective or Voluntary Enhancement – Elective or voluntary enhancement procedures, services, and medications provided to improve weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging or mental performance, including, but not limited to, growth hormone, testosterone, salabrasion, laser surgery or other skin abrasion procedures associated with the removal of scars or tattoos, including acne scars regardless whether Plan benefits were paid to treat the condition that caused the scars.
22. Electrical continence aids; anal or urethral.
23. Enteral Feeding Food Supplement – The cost of outpatient enteral tube feedings or formula and supplies, except as expressly listed in Appendix B.
24. Examinations – Physical, psychiatric, or psychological examinations or testing, vaccinations, immunizations, or treatments conducted for purposes of medical research or to obtain or maintain a license of any type.
25. Exercise equipment.
26. Eyeglasses and Contact Lenses – provision or fitting of eyeglasses or contact lenses, except as expressly listed in Appendix B.
27. Orthoptic therapy and eye exercises, radial keratotomy, Lasik, and other refractive eye surgery, except as provided in Appendix B under Vision Therapy.
28. Food or Food Supplements.
29. Gender conforming or gender reassignment services except in the case of a child born with ambiguous or atypical genitalia
30. Gene therapy products and their administration.
31. Growth hormone, except as expressly listed in Appendix B.
32. Hair analysis, hair styling, wigs, and hair transplants, whether or not ordered by a Physician.
33. Home Services to help meet personal, family, or domestic needs.
34. Health and athletic club Membership – Any expenses of enrollment and Membership in a health, athletic or similar club.
35. Hearing therapy.
36. Household Equipment and Fixtures – Purchase or rental of household equipment, such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses, or waterbeds.
37. Home obstetrical delivery.
38. Hypnotherapy.
39. Hypnosis.
40. Illegal Activity - Injury or Sickness resulting from participation in or, as a consequence of having participated in, any criminal or Illegal Activity or enterprise.
41. Immunizations for travel or employment, except as expressly listed in Appendix C.

42. Infertility Services – Health services and associated expenses for the treatment of infertility including, but not limited to, artificial insemination, ICSI (intracytoplasmic sperm injection), in vitro or in vivo fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, reversal of voluntary sterilization, surrogate parenting, selective reduction, cryopreservation, travel costs, donor eggs or semen and related costs including collection and preparation, non-Medically Necessary amniocentesis, and pharmaceutical agents used for the purpose of treating infertility.
43. Maintenance therapy.
44. Massage therapy.
45. Military Health Services – Services and supplies furnished to any Covered Person who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or used to diagnose or treat disabilities resulting from military service of a Covered Person who is legally entitled to other coverage which is reasonably available; or used to diagnose or treat disabilities resulting from service in the armed forces of another country.
46. Missed appointment charges or charges for time spent traveling.
47. Naturopathic or holistic services.
48. No Charge to Covered Person – Services and supplies furnished to a Covered Person without charge, such as part of a study, grant or research program, free clinics, free government programs, court-ordered care, or that portion of any charge which would not be made but for the availability of benefits from the Plan.
49. Non-emergency care when traveling outside the United States.
50. Over-the-counter supplies and medications unless expressly listed under covered services and supplies.
51. Prescription drugs except as provided through the Prescription Drug Benefit.
52. Private duty nursing services.
53. Self-Injectable medications, except as covered in the Prescription Drug Benefit.
54. Third-Party Liability - Services or supplies received to diagnose or treat any Injury or Sickness sustained due to the act or omission of a third-party unless the Covered Person has fully complied with the reimbursement and subrogation provisions of this Plan.
55. Smoking cessation programs, except the Plan's approved program covered as a listed Preventive benefit.
56. Transportation for delivery of home health care.
57. Transsexual surgery and associated charges including, without limitation, gender reassignment and gender conforming services.
58. War-Injury or Sickness sustained outside of military service as a result of war or any act of war, whether declared or undeclared, or insurrection, or any atomic explosion or other release of nuclear energy (except nuclear therapy used solely for medical treatment of an Injury or Sickness), whether in peacetime or wartime and whether intended or accidental.
59. Weight loss medications and procedures intended primarily for weight loss, unless treatment is Medically Necessary due to morbid obesity defined by the National Institute of Health (NIH) guidelines.

Appendix E

Drug-Specific Limitations

1. **Accrufer (ferric maltol)**
   Covered only with Prior Authorization.
2. **Aimovig**
   Covered only with Prior Authorization, only for patients with eight or more headache days per month, and who have tried and failed at least two triptans, and who have tried and failed at least two prophylactic pharmacologic therapies, each from a different class (e.g., Botox, angiotensin receptor blocker, angiotensin converting enzyme inhibitor, anticonvulsant, beta-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant).
3. **Airduo RespiClick**
   Covered only as a generic, with Prior Authorization, and only for patients 12 years old and older.
4. **Amjevita**
   Covered only as a specialty drug for all Humira indications if requested by physician.
5. **Antidepressants**
   Only generic drugs are covered, unless the prescribing Physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to not be effective, or to cause an adverse reaction in the patient.
6. **Antipsychotics**
   Only generic drugs are covered, and for children under the age of 5 years, only with Prior Authorization. Brand drugs are covered only if the prescribing Physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to not be effective or to cause an adverse reaction in the patient.
7. **Attention Deficit (CNS Stimulants)**
   Only generic drugs are covered, and for Covered Persons over the age of 18 years, only with Prior Authorization. If more than one CNS stimulant is prescribed at the same time, only one will be covered. Brand drugs are covered only if the prescribing Physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to not be effective, or to cause an adverse reaction in the patient.
8. **Balversa (erdafitinib)**
   Covered only with Prior Authorization.
9. **Benlysta**
   Covered only with Prior Authorization and per FDA indications and dosage.
10. **Braftovi**
    Covered only with Prior Authorization, after confirmation not being used for wild-type BRAF melanoma and for BRAF V600E or V600K mutation.
11. **Epclusa**
    Covered as a specialty drug only with Prior Authorization for FDA approved indications, and in accordance with the UBC Clinical Advisory Committee Hepatitis C Treatment Statement dated January 2015.

12. **Epidiolex**

    Covered only with Prior Authorization, only when a neurologist prescribes the first dose after obtaining baseline ALT/AST and bilirubin values.

13. **Erelzi**

    Covered only as a specialty drug for all Enbrel indication if requested by physician.

    The Plan's coverage of routine vaccinations for Diphtheria, Tetanus and Pertussis (DPT); Haemophilus Influenzae type B; Hepatitis; Herpes Zoster; Human Papillomavirus; Influenza; Measles, Mumps and Rubella; Meningococcal; Pneumococcal; Polio Virus; Rotavirus; and Varicella will be limited in accordance with the age limitations set forth in the Express Scripts "Immunizations/Vaccines Cross Reference Guide – 2017".

14. **Erleada**

    Covered only with clinical Prior Authorization, only for FDA approved indication, only if prescribed by an oncologist, and only for patients receiving a gonadotropin-releasing hormone analog or who have had bilateral orchiectomy. This is a specialty drug to the specialty short fill trials.

15. **Galafold**

    Covered only with Prior Authorization.

16. **Gattex (teduglutide) S.C. injection**

    Covered only with Prior Authorization.

17. **Haegarda**

    Covered only with Prior Authorization, only for patients 13 years old and older, only for patients having an attack associated with hereditary angioedema, only for diagnosis of HAE based on normal C1 and low C4, only on patients not on a medication known for causing drug induced HAE, and only when prescribed by an allergist, immunologist, hematologist, or dermatologist.

18. **Hepatitis C Drugs 2**

    Covered only with Prior Authorization and per FDA indications and per revised CAC position statement changing the Metavir score criteria.

19. **Ingrezza**

    Covered only after obtaining an Abnormal Involuntary Movement Scale score, with Prior Authorization, for an initial period of 8 weeks. Reassess after 8 weeks with new AIMS score, and discontinue if on 80 mg dose with improvement of less than 2 points. If on 40 mg dose with less than 2 point improvement, allow renewal with increase to 80 mg dosage. Thereafter, reassess every 8 weeks and discontinue coverage if AIMS improvement is less than 2 points.

20. **Jadenu, deferasirox**

    Covered as specialty drug, only for FDA indication, and only when the patient's medical records show that all of the following criteria have been satisfied: serum creatinine clearance, serum transaminases and bilirubin are satisfactory per Black Box Warning; if patient has hepatic impairment, Child-Pugh class must not be severe (class C) and dosage must be reduced if moderate (Class B). If criteria are satisfied, initial coverage depends on quarterly documentation of serum transaminases and bilirubin every two weeks during the first month and at least monthly thereafter for the first year.

21. **Jornay PM**

    Non-preferred medication for patients 18 years and under. Covered only with Prior Authorization for new starts over age 18.

22. **Lenvima, lenvatinib**

    Covered as specialty drug, only when the patient's medical records show that all of the following criteria have been satisfied: prescribed by an oncologist; covered only for treatment of differentiated thyroid cancer.

23. **Mavenclad (cladribine)**

    Covered only with Prior Authorization.

24. **Mavyret**

    Covered only with Prior Authorization and per FDA indications and per UNC CAC Hepatitis Position Statement.

25. **Mayzent (siponimod)**

    Covered only with Prior Authorization.

26. **Nayzilam (midazolam) nasal spray**

    Covered only with Prior Authorization by Neurologist only.

27. **Nubeqa (darolutamide)**

    Covered only with Prior Authorization by Oncologist only; Add to Short Fill List.

28. **Orkambi, lumacaftor/ivacaftor**

    Covered as specialty drug, only when the patient's medical records show that all the following criteria have been satisfied: prescribed by a pulmonologist; documentation of 2 copies of F508del mutation. If criteria are satisfied, initial coverage is for 6 months, with continued coverage dependent on response reassessed at that time.

29. **Pain Medications**

    Products containing acetaminophen are covered only for prescribed cumulative daily dosage of 4 g or less.

    - Oxycodone coverage is limited to 180 mg daily maximum.
    - Oxymorphone coverage is limited to 120 mg daily maximum.
    - Hydromorphone coverage is limited to 24 mg daily maximum.
    - Oxycontin is covered only after a 60-day trial and failure of each of the following: Morphine ER (extended release), methadone, fentanyl patches, and oxymorphone ER and limited to a treatment period of 90 days. Prescriptions are covered from only one prescriber at a time and are further limited to 90 pills per 30-day period per cumulative strength. After exhaustion of a 90-day supply, one further fill for up to 3 days will be covered if prescribed during a visit to an Emergency room or urgent care facility.
    - Buprenorphine is covered only for malignant pain, limited to 1 x 60 blister pack every 30 days.

30. **PCSK9 drugs**

    PCSK9 drugs, generic or brand name, are covered as specialty drugs, only when the patient's medical records show that all of the following criteria have been satisfied: prescribed by a cardiologist; Familial Hypercholesterolemia confirmed and documented; the patient has tried high-intensity statin therapy with resulting baseline fasting lipid levels greater than 100 mg/dl or 190 mg/dl if statin intolerant; and patient has tried and failed at least one non-statin therapy for 6 months. If criteria are satisfied, initial coverage is for 3 months; if successful, continuing coverage is for 12 months.

31. **Piqray (alpelisib)**
    Covered only with Prior Authorization.
32. **Ruzurgi (amifampridine) oral**
    Cover Ruzurgi only; Firdapse not covered.
33. **Skyrizi (risankizumab-rzaa)**
    Covered only with Prior Authorization.
34. **Sonidegib**
    Covered only as a specialty drug, upon prior authorization, when the patient's medical records show that both of the following criteria have been satisfied:
    a) Prescribed by an oncologist or dermatologist; and
    b) Dosage limited to 200 mg daily.
35. **Spravato (esketamine) nasal spray**
    Covered only with Prior Authorization.
36. **Statins**
    Only generic drugs are covered. After August 1, 2016, new statins or statin combinations products are not covered unless approved by the Trustees.
37. **Stomach (gastric) acid reduction Proton Pump Inhibitors (PPIs)**
    Only generic prescription products that are non-combination omeprazole, pantoprazole or lansoprazole are covered.
38. **Suboxone**
    Covered only when prescribed for opioid dependence with accompanying Physician's treatment plan. Coverage is limited to one year.
39. **Sunosi (solriamfetol)**
    Covered only with Prior Authorization.
40. **Syndros**
    Coverage for generic only, for patient who cannot swallow a pill.
41. **Takhzyro**
    Covered only with Prior Authorization, when prescribed by an allergist, immunologist, hematologist, or dermatologist, for a patient who is 12 years or older, with a diagnosis of HAE based on normal C1 level and low C4 level, who is not taking a medication known to cause drug-induced angioedema.
42. **Tecentriq**
    Covered only with Prior Authorization for FDA approved indications.
43. **Tibsovo**
    Covered only with Prior Authorization, only with confirmed IDH1 mutation.
44. **Triptodur**
    Covered only with Prior Authorization and per FDA indications and dosage.
45. **Turalio (pexidartinib)**
    Covered only with Prior Authorization by Oncologist only; Add to Short Fill List.
46. **Vosevi**
    Covered only with Prior Authorization and per FDA indications and per UNC CAC Hepatitis Position Statement.
47. **Vyndaqel (tafamidis meglumine) and Vyndamax (tafamidis)**
    Covered only with Prior Authorization.

48. **Xadago**

    Not covered as a single therapy. Covered only with verification that usage is not as monotherapy, with starting dosage limited to 50 mg, one per day, limited to 30 days.

49. **Xiidra**

    Covered only with Prior Authorization for treatment of severe dry-eye such as Sjorgren's Syndrome, or failure of other less costly treatments.

50. **Xpovio (selinexor)**

    Covered only with Prior Authorization by Oncologist only; Add to Short Fill List.

51. **Zinbryta subcutaneous**

    Covered as a specialty drug only with Prior Authorization and when the patient's medical records show that all of the following criteria have been satisfied: failure of at least two other prior therapies such as Avonex or Rebif, Copaxone, Tecfidera or Gilenya; submission of satisfactory current Liver Function Tests; initial approval limited to 3, and thereafter annual review; new LFTs submitted for each renewal.

52. **Zulresso (brexanolone); intravenous solution**

    Covered only with Prior Authorization through Accredo Specialty Pharmacy/Meritain.

Appendix F

Prescription Drug Exclusions

1. Non-sedating antihistamines (NSAs).
2. Medications available without prescription over the counter, except as expressly noted in the Plan.
3. Any drug if and after the patient has failed to comply with or complete the covered course of treatment prescribed for that drug.
4. Drugs intended for use in a Physician's office or intended as samples.
5. Immunization agents, biological serum, vaccines, or biologicals covered under the Medical Benefit except as provided in Section III.B.2.
6. Experimental or Investigative drugs.
7. Drugs a Covered Person is eligible to receive without charge under any workers' compensation law, or any municipal, state, or federal program.
8. Rogaine, Renova, Propecia, or any other medication prescribed for the treatment of hair loss.
9. Zyban and other smoking cessation agents, such as gum, patches and nasal spray including Nicorette, Habitrol, Nicoderm, Nicotrol, and ProStep, unless provided through a smoking cessation program approved by the Plan.
10. Weight loss medications.
11. Tri-Vi-Flor and other pediatric vitamins containing fluoride (except for children older than 6 months of age through 5 years old).
12. Any dental products, including fluoride preparations and rinses such as Luride and Phos-Flur (except for children older than 6 months of age through 5 years old).
13. Drugs used to enhance or improve fertility.
14. Anabolic steroids, including Anadrol, Oxandrin, and Winstrol.
15. Any drugs, services or devices that do not satisfy the General Conditions of Coverage set forth in Section III.B.1.
16. Drugs not FDA approved for the condition for which prescribed.
17. Testosterone for female patients.
18. Aczone.
19. Adhansia XR (methylphenidate).
20. Advair.
21. Adzenys XR-ODT.
22. Aemcolo (rifamycin).
23. Altreno.
24. Ameluz.
25. Amphetamine.
26. Apadaz.
27. Bevyxxa.
28. Bijuva (estradiol/progesterone).
29. Brand formulation RyVent.

30. Brilinta.
31. Bryhali (halobetasol).
32. Byvalson.
33. Carbinoxamine maleate generic.
34. Cariprazine.
35. Cassipa.
36. Cequa.
37. Consensi.
38. Contempla XR ODT.
39. Dithol Kit.
40. Doryx MPC.
41. Duobril (halobetasol/tazarotene).
42. Endari.
43. Evekeo ODT (amphetamine sulfate).
44. Evenity (romosozumab-aqqg).
45. Exondys infusion.
46. Farydak.
47. Gloperba (colchicine).
48. Glumetza.
49. Horizant.
50. Hysingla ER and Nucynta ER.
51. Ilumya, unless and until pricing is approved by Trustees.
52. Imvexxy.
53. Inbrija (levodopa).
54. Inveltys.
55. Jatenzo (testosterone undecanoate).
56. Jynarque.
57. Keralyt-rx.
58. KyBella.
59. Lexette (halobetasol).
60. Lokelma.
61. Lonhala Magnair.
62. Lotemax SM (loteprednol).
63. Lucemyra.
64. LymePak.
65. Meloxicam.
66. Methylphenidate.
67. Minocycline ER.
68. Minolira.

69. Morphine.
70. Motegrity (prucalopride).
71. Mydayis.
72. Myxredlin (insulin human in sodium chloride).
73. Natpara.
74. Nocdurna.
75. Noctiva Nasal Spray.
76. Nuedexta, unless prescribed and in use before May 1, 2017.
77. Nuplazid.
78. Onzetra.
79. Osmolex ER.
80. Otovel.
81. Oxycodone.
82. Patiromer.
83. Portrazza.
84. Qbrexza.
85. Quillichew XR.
86. Rayos (prednisone extended release).
87. Relistor (any formulation).
88. Rocklatan (netarsudil/latanoprost).
89. Roxybond.
90. Seysara.
91. Siliq.
92. Solosec.
93. Sympazan (clobazam).
94. Symproic.
95. Taltz.
96. Tiglutik.
97. Tolsura (itraconazole).
98. Tosymra (sumatriptan).
99. Toujeo.
100. Trifluridine/Tipiracil.
101. Tuzistra XR.
102. Vascepa (icosapent) oral.
103. Vyleesi (bremelanotide).
104. Xelpros.
105. Xofluza.
106. Xyosted.
107. Yonsa.

108. Yupelri (revefenacin).
109. Zecuity.
110. Zembrace.
111. Zerivate.
112. Zolgensma (AVXS 101 - onasemnogene abeparvovec); one-time intravenous infusion.
113. ZTLido (lidocaine patch 1.8%).
114. Zurampic.
115. Zypitamag.

Appendix G

Special Eligibility Provisions

COVID-19 2020 Plan Year Relief Payment Eligibility

A Member whose eligibility was continued through March 31, 2021 pursuant to the COVID-19 Plan Year Relief Payment Eligibility Amendment, adopted in 2020, shall continue to participate through such date pursuant to the terms specified therein.

Appendix H

Uniformed Services Employment and Reemployment Rights Act

The Plan is administered in compliance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, during a period of "service in the uniformed services" a Member will have the opportunity to continue coverage under the Plan for himself or herself and his or her spouse and covered dependents if coverage under the Plan is lost due to the Member's absence from covered employment for service in the uniformed services. USERRA continuation coverage is separate and independent from COBRA continuation coverage, which is described in Section I.D. of this Plan Document.

This Appendix H provides a summary of a Member's rights and obligations under USERRA's continuation coverage provisions. For additional information about your USERRA rights and obligations under the Plan and a copy of the procedures for electing USERRA continuation coverage, contact the Benefit Office.

Service in the Uniformed Services.

The Plan follows the definition of "service in the uniformed services" under 38 U.S.C. § 4303(1), which includes the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, absence from work for an examination to determine a person's fitness for any type of duty, funeral honors duty performed by National Guard or reserve members, or duty performed by intermittent disaster response personnel for the Public Health Service.

Period of USERRA Continuation Coverage

The period during which a Member may maintain USERRA continuation coverage will generally terminate on the earlier of:

a. The last day of the 24-month period beginning on the first day of military leave, or
b. The date the Member fails to apply for reemployment, as required under USERRA, after returning from military leave.

Notwithstanding the preceding paragraph, USERRA continuation coverage will terminate for the following reasons:

a. the contributed employer no longer provides group health coverage to any of its employees,
b. the premium for USERRA continuation coverage is not paid on time (including any grace period),
c. the Member's failure to return from service or apply for a position of employment as required under USERRA, or
d. termination for cause under the generally applicable terms of this Plan (e.g., intentional misrepresentation by a Member).

Cost of USERRA Continuation Coverage

A Member who has established eligibility for coverage based on hours in accordance with Section I.C.1.c) may elect to continue coverage under USERRA until the expiration of such eligibility. If eligibility is exhausted, or the Member chooses to pay for USERRA continuation coverage to maintain the hours credited to him or her under the Plan, the cost of coverage to the Member for coverage will be determined as follows:

a. If the Member is absent from covered employment for less than 31 days, he or she must pay the regular cost of coverage for a Member under the Plan.
b. If the Member is absent from covered employment for 31 or more days, he or she must pay an amount that does not exceed 102% of the full cost of coverage under the Plan, as determined for purposes of COBRA continuation coverage.

Summary Plan Description about Administrative Information

Plan Name	The Plan is the Carpenters' Health and Welfare Trust Fund of St. Louis dba St. Louis – Kansas City Carpenters Regional Health Plan.
Plan Sponsor and Plan Administrator	The administrator is the Board of Trustees of Carpenters' Health and Welfare Trust Fund of St. Louis, 1401 Hampton Avenue, St. Louis, MO 63139, 314.644.4800. The Trustees are responsible for the operation of the Plan. Any administrative services provider will provide duties specified in a separate Administrative Services Agreement entered into between that provider and the Trustees. A complete list of employers and employee organizations sponsoring the Plan may be obtained upon written request to the administrator and is available for examination at the administrator's office. Upon written request to the administrator, participants and beneficiaries may receive information as to whether a particular employer or employee organization is a sponsor of the Plan and if so, the sponsor's address.
Contributions and Funding Medium	Contractually determined contributions are made to the Plan by employers and self-payments are made by members in amounts determined by the Trustees. Contributions are made to the St. Louis - Kansas City Carpenters Regional Health and Welfare Trust Fund, which provides funding for benefits.
Employer Identification Number	43-0685432
Plan Number	501
Plan Type	The Plan is a group health welfare plan providing medical care, prescription drug coverage, dental care, vision care, life, accidental death and dismemberment, weekly accident and sickness, and safety enhancement benefits.
Plan Year	May 1 – April 30
Type of Funding	The benefits described in this SPD are self-funded except for Life Insurance and Accidental Death and Dismemberment Insurance benefits, which are currently insured by MetLife.
Collective Bargaining Agreements	The Plan is established and maintained pursuant to collective bargaining agreements and participation agreements between employers and the Carpenters' District Council of Greater St. Louis and Vicinity. Contributions are made to the Fund by participating employers for active members. The Plan contains a self-payment provision for underemployed, retired, disabled, and self-employed members and surviving spouses as well as COBRA continuation premiums. Copies of the collective bargaining agreement may be obtained upon written request to the administrator, and are available for examination at: St. Louis – Kansas City Carpenters Regional Council 1401 Hampton Avenue St. Louis, Missouri 63139 Telephone: 314-644-4800 Toll free: 800-332-7188 union@carpdc.org
Agent for Service of Legal Process	Service of Legal Process may be made upon the Plan Administrator, Secretary of the Board of Trustees, or an individual Trustee at: Carpenters' Health and Welfare Trust Fund of St. Louis 1419 Hampton Avenue St. Louis, Missouri 63139

Amendment of Termination

The Board of Trustees has the right to amend or terminate the Plan in whole or in part at any time.

Administrative Service Providers

Medical Benefits
Cigna HealthCare
P.O. Box 182223
Chattanooga, TN 37422
Website: www.cigna.com

Member Assistance Program (MAP)
Mercy Managed Behavioral Health
1000 Des Peres Road, Suite 200
St. Louis, Missouri 63131
Website: **www.mbh-eap.com**

Dental Benefits
Delta Dental of Missouri
P.O. Box 8690
St. Louis, Missouri 63126
Website: **www.deltadentalmo.com/carpdc**

Prescription Drug Benefits
Express Scripts/Medco
100 Parsons Pond Drive
Franklin Lakes, New Jersey 07417
Website: **www.express-scripts.com**

Specialty Prescription Drug Benefits
Diplomat Pharmacy
P. O. Box 321130
Flint, MI 48532
Website: **http://diplomat.is/**

Vision
VSP
3333 Quality Drive
Rancho Cordova, California 95670
Website: **www.vsp.com**

Life Insurance
MetLife
Attn: Life Claims Department
P. O. Box 6115
Utica, New York 13504-6115
Website: **www.metlife.com**

No Vesting

No benefits vest under the Fund.

Restatement Date of SPD

This SPD is effective as of January 1, 2021

Board of Trustees

The Board of Trustees consists of Employer and *Union* Trustees. Employer Trustees are appointed by a bargaining agency that represents contributing employers. Union Trustees are appointed by the St. Louis – Kansas City Carpenters Regional Council.

Union Trustees	Employer Trustees
Al Bond (Managing Trustee and Secretary) 1401 Hampton Avenue St. Louis, MO 63139	Robert Calhoun (Chairperson) Calhoun Construction Management 6600 W. Main Street (Rear) Belleville, IL 62223
Donald Brussel Jr. 1401 Hampton Avenue St. Louis, MO 63139	Jim Sauer Fixture Contracting Co. Inc. 10630 Midwest Industrial Blvd. St. Louis, MO 63132
Keith Taylor 1401 Hampton Avenue St. Louis, MO 63139	Timothy Schoolfield Country Side Carpets and Interiors, Inc. 1305 Tom Ginnever Ave. O'Fallon, MO 63366
Dan Neiswander 1401 Hampton Avenue St. Louis, MO 63139	Craig McPartlin Con-Tech Carpentry 366 W. Fourth St. Eureka, MO 63025
Mike Gavoli 8955 E. 38th Terrace Kansas City, MO 64129	Kevin Deptula Builders Bloc 607 Trade Center Blvd. Chesterfield, MO 63005
Todd Hake 1401 Hampton St. Louis, MO 63139	Gregory Hesser Alberici Constructors Inc. 8800 Page Ave. St. Louis, MO 63114
Rocky Kloth 8955 E. 38th Terrace Kansas City, MO 64129	Brian Murphy BAM Contracting LLC 2342 LaSalle St. St. Louis, MO 63104
Scott Byrne 1401 Hampton Avenue St. Louis, MO 63139	Gerhard K. Glassl The Up Companies 2060 Craigshire Rd. St. Louis, MO 63146

No Guarantee of Employment

Your coverage by the Plan does not constitute a guarantee of your continued employment.

Plan Inspection and QMCSO Procedures

If you want to inspect or receive copies of additional documents relating to the Plan, contact the Benefit Office. You will be charged a reasonable fee to cover the cost of copying any documents requested.

Participants and beneficiaries can obtain from the administrator, without charge, a copy of the Plan's procedures governing qualified medical child support order determinations.

Rescission

The Plan will not rescind health coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage for health benefits that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance has only a prospective effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. Retroactive elimination of coverage back to the date of termination of employment is not a rescission if due to a delay in administrative recordkeeping if the employee does not pay any premiums for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactive to the date of divorce.

The Plan is required to provide at least 30 days advance written notice to each participant who is affected by a rescission of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group. Retroactive termination of coverage in cases of an unreported divorce or failure to timely pay premiums is not an Affordable Care Act rescission and, therefore, the 30-day advance notice requirement does not apply.

Discretionary Authority

The Trustees have the power and authority to amend or terminate the Plan, to increase, decrease, or change benefits and premiums, or change eligibility rules or other provisions of the Plan of Benefits for the Gold or Platinum Medical Plans, in their discretion as may be proper or necessary for the sound and efficient administration of the Fund, provided that such changes are not inconsistent with law or with the provisions of this Plan or with the provisions of the *Trust Agreement*.

The Trustees and other Plan fiduciaries and individuals, to whom responsibility for the administration of the Plan has been delegated, have the full discretionary authority available under applicable law to construe the trust agreement, Summary Plan Description, the Plan, the Plan documents and related documents including but not limited to collective bargaining agreements, participation agreements and reciprocity agreements, and the procedures of this Fund, to interpret any facts relevant to such construction. This authority extends to every aspect of their administration of the Plan including benefit determinations, eligibility determinations and entitlement to Plan benefits. Any interpretation or determination made under this discretionary authority will be given full force and effect and will be accorded judicial deference, unless it can be shown that the interpretation or determination was arbitrary and capricious. Benefits under the Plan will be paid only if the Trustees (or other Plan fiduciaries, such as a third-party Claims Fiduciary) decide in their discretion that the claimant is entitled to them. In addition, any interpretation or determination made pursuant to this discretionary authority is binding on all involved parties.

Plan Amendment and Plan Termination

The Plan may be amended or terminated by the Trustees in accordance with the terms of the Trust Agreement and the applicable collective bargaining agreements. In the event the Plan is terminated, any remaining funds will be used for benefits until the funds are exhausted. The Trustees reserve the right to amend or terminate this Plan at any time and in any manner, subject to the terms of any collective bargaining agreement or insurance policy pursuant to which Plan benefits are provided. In the event of a termination of the Trust, all liabilities of the Plan shall be satisfied to the extent and as provided by the Trust Agreement, insurance policy or other agreement with an insurer, third-party administrator or other entity, and any applicable law, provided, however, that any Plan amendment or termination may be limited by the terms of any insurance policy or agreement with a third-party underlying or funding a benefit of this Plan. Amendments to the Plan shall be adopted by action of the Trustees at a regular or special meeting of the Trustees, and shall be recorded in the minutes of such meeting, or in a formal document executed by the Trustees as an amendment to the Plan documents. Any such amendment to the Plan shall become effective upon adoption, or if a different effective date is specified by the Trustees, on such specified date.

If an amendment to the Plan is recorded in minutes of the meeting at which it is adopted, the amendment shall be given effect as recorded in the minutes. If such amendment to the Plan is thereafter incorporated in a formal document executed by the Trustees as an amendment to the Plan document, the provisions of the formal document shall, upon execution, supersede the provisions of the meeting minutes with respect to such amendment to the Plan.

Furnishing Required Information and Documentation

Every covered person shall, upon reasonable request, furnish the Board of Trustees such information or proof as may be reasonably necessary or helpful in determining eligibility or benefit payments. Failure on the part of the covered person to comply with any request for information shall be grounds for denying or discontinuing benefits to such covered person until the request is complied with. If any covered person knowingly makes any false statement concerning any fact material to his claims for benefits, the Board of Trustees shall have the right to recover any payment made to such person in reliance on such false statements.

ERISA Rights

As a participant in the Carpenter's Health and Welfare Trust Fund of St. Louis, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Benefit Office, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The Fund Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Fund's annual financial report. The Fund 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, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of 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.

No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If a 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 Plan documents or the latest annual report from the Plan and if you do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay costs and legal fees. If you are successful, the court may order the person sued to pay costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), 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.