St. Louis-Kansas City Carpenters Regional Health Plan – *Basic Plan*
Medical, Prescription, Dental & Vision Schedule of Benefits as of 7/1/23

Basic Medical Schedule of Benefits

BENEFIT	UHC Choice Plus In-Network Coverage Only
Annual Deductible – Participant Responsibility	$1,000 Individual / $3,000 Family
Annual Out-Of-Pocket Maximum – Participant Responsibility	$5,600 Individual / $11,200 Family
Coinsurance – Participant Responsibility	30%
PREVENTIVE CARE	
Routine Preventive Care	Plan Pays 100% Participant Pays 0%
Routine Mammogram	Plan Pays 100% Participant Pays 0%
Routine Colonoscopy	Plan Pays 100% Participant Pays 0%
OFFICE VISITS – NON-ROUTINE	***Participant Pays***
Primary Care Physician Office Visit	$25 Copay
Specialist Office Visit	$50 Copay
Mental Health and Substance Abuse Office Visit	$25 Copay
UMR Telehealth Services / Teladoc 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. No charge for Medicaland 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.	$0 Copay
OUTPATIENT SERVICES[1]	***Participant Pays***
Outpatient Surgery[1, 4]	Deductible & 30%
Hearing Aid Participant only benefit limited to $2,000 per ear every 5 years.	Deductible & 30%
Lab LabCorp and Quest Diagnostics Outpatient facilities for labs means an outpatient hospital-owned lab.	LabCorp / Quest: $0 Copay, No Deductible Outpatient Lab: Deductible & 30%
Radiology, Xray, Anesthesia, Pathology, and other Ancillary Services CT, PET, MRI Scans, Nuclear Scans and Other Diagnostic Services[1] Free-standing centers operate independently outside hospitals. Facility for radiology means an outpatient hospital system-owned radiology center.	Free-Standing Facility: $25 Copay Hospital-System Owned Facility: Deductible & 30%
Physical, Speech and Occupational Therapy Limited to combination of 60 visits annually.	$25 Copay
All other therapies – Includes Cognitive Therapy and Pulmonary Rehab Limited to combination of 60 visits annually.	Deductible & 30%
Durable Medical Equipment, Orthotics and Prosthetics[1] Foot orthotics limited to $1,000 Annual Maximum.	Deductible & 30%

BENEFIT	UHC Choice Plus In-Network Coverage Only *Participant Pays*
Breast Feeding Equipment and Supplies Limited to the rental of one breast pump per birth as ordered or prescribed by physicians. Includes related supplies.	0% Coinsurance
Home Health Services/ Hospice[1]	Deductible & 30%
Outpatient Mental Health and Substance Abuse – All Other Services[1]	Deductible & 30%
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.	$10 Copay
INPATIENT SERVICES[1]	***Participant Pays***
Inpatient Hospital Services[1, 4]	Deductible & 30%
Convalescent Skilled Nursing Facility[1] Aggregate 100-day maximum cross accumulates among all benefit levels	Deductible & 30%
Mental Health Substance and Abuse Residential Care[1]	Deductible & 30%
Observation Room[1]	Deductible & 30%
Physician Hospital Visits and Specialist Care/Consultations	Deductible & 30%
Inpatient Ancillary Services (Emergency Room, Radiology, Anesthesiology, Pathology)	Deductible & 30%
EMERGENCY AND URGENT CARE[2]	***Participant Pays***
Hospital Emergency Room[2]	$250 Copay & 30% Coinsurance
Urgent Care Facility[3]	$75 Copay
Ambulance Service - Ground[3]	$150 Copay
Ambulance Service - Air[3]	$1,000 copay

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

[2]In the event a patient is admitted through the Emergency Room at an In-Network or Non-Network provider, the Emergency Room copay is waived, and deductible/coinsurance applies. If an ER patient is not admitted as an inpatient but required emergency treatment, the Emergency Room copay and coinsurance are 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. Generally, non-emergency care by a Non-Network Provider is not covered.

[3]In an In-Network Urgent Care Facility or Ambulance transport, 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.

[4]If the patient is able to participate in the Orthopedic Health Support program through a center of excellence, participant coinsurance may decrease to 10%.

Prescription Schedule of Benefits

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

PRESCRIPTION BENEFIT SCHEDULE	MIN/MAX Copay per script		Participant Coinsurance
Up to 30-day supply through Retail[1] or Mail Order			
Generic Medication	$10	$20	10%
Preferred Brand[2] Drug Medication	$20	$75	30%
Non-Preferred Brand[2] Medication	$30	$125	40%
Diabetes and Insulin Supplies *(including short-term continuous glucose monitors)*	$10	$50	10%
90-day supply through Retail[1] or Mail Order			
Generic Medication	$20	$40	10%
Preferred Brand[2] Drug Medication	$40	$150	30%
Non-Preferred Brand[2] Medication	$60	$250	40%
Diabetes and Insulin Supplies	$20	$100	10%
Non-Select Specialty Medications			
Preferred Brand[2] Drug Medication	$40	$150	35%
Non-Preferred Brand[2] Medication	$40	$250	40%
Select Specialty Medications			
Must Enroll in SaveonSP Program, call 800.683.1074	$0		0%
If Not Enrolled in SaveonSP Program	No MAX		30% Minimum
Select Specialty Drugs may be found on the SaveonSP Specialty Drug list: ***www.saveonsp.com/carpdc***			*Does not count toward out-of-pocket*
Individual Annual Out-of-Pocket	$3,500 Individual / $7,000 Family		

[1]**Restricted Retail Pharmacy Network** – Medications for maintenance or long-term use must be filled by mail order or at a pharmacy participating in our Restricted Retail Pharmacy Network for a 90-day supply. The 90-day copay schedule above will apply. If mail order or the Restricted Retail Pharmacy Network is not used, you will pay the full cost of the drug. For a list of participating pharmacies on the Restricted Retail Pharmacy Network, log in or register at **express-scripts.com/90day** or call Express Scripts at 866.890.1419.

[2]**Member Pays the Difference** – When you fill a brand prescription when the generic equivalent is available, you pay the difference in the brand cost versus the generic cost plus the generic copay. Generic drugs are the same active chemical elements as the brand name drugs. Check with your doctor or pharmacist about taking advantage of generic drugs with lower copays. If you are not able to take the generic due to documented clinical reasons, please submit an appeal to pay the brand copay even though a generic is available.

Dental Schedule of Benefits

The Plan's contracted Network Sponsor to-date 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.

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

Deductibles, Coinsurance and Maximum Benefit Limits

LIMITATION	PPO NETWORK	PREMIER NETWORK
Annual Deductible Preventive Services	Participant Pays $0	Participant Pays $50
Preventive Services	Participant Pays 0% Plan Pays 100%	Participant Pays Deductible and 25% Plan Pays 75%
Basic Services	Not covered	Not covered
Major Services	Not covered	Not covered
Orthodontic Services	Not covered	Not covered
Annual Maximum Benefit, excluding Orthodontia	Not covered	Not covered
Lifetime Maximum Benefit, Orthodontia Only	Not covered	Not covered

CLASSIFICATION AND LIMITATION OF COVERED DENTAL 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.

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
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.
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 aged 19 and older undergoing head and neck radiation, fluoride applicationsare covered twice per calendar year.

Please refer to the Health Plan Document for detailed information.

Vision Schedule of Benefits

The Plan's Network for the Vision Benefit is the Vision Service Plan (VSP) Network. Covered Persons should obtain covered services and supplies from In-Network Providers. In-Network vision Providers are named and updated on the VSP website at www.vsp.com.
Under the Basic Plan, Covered Persons have ***access to VSP discounts only***. The Plan does not cover any services with copay or coinsurance.

Life Insurance Benefits

The Plan provides Life and Accidental Death and Dismemberment (AD&D) benefits under policies insured by a commercial insurance company. A Member is eligible for Life insurance and AD&D benefits so long as the Member is eligible for medical benefits under the Plan, *except for* participants covered under the Non-Bargained Office Employee group and participants with COBRA coverage.

BENEFIT	AMOUNT *Plan Pays*
Insurance on Life of Member	$8,000
Insurance on Life of eligible Dependent	$2,000
AD&D death benefit (Members only) • *Life* • *One hand, one foot or sight of one eye* • *Both hands, both feet, sight of both eyes or any combination of two or more of the above losses*	Up to $8,000 *100%* *50%* *100%*

St. Louis-Kansas City Carpenters Regional Health Plan – Basic Plan
Carpenters Wellness Center Schedule of Benefits as of 7/1/2023

CARPENTERS BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

Schedule of Benefits

WELLNESS CENTER BENEFIT / FEES	YOU PAY
MEDICAL	
All Scheduled Provider Visits *Includes Preventive Care, Condition Management, Procedures, Chiropractic, Medical Massage Therapy (wellness center provider referral only), Physical Therapy, Coaching, Counseling, Audiology*	$0
Durable Medical Equipment (DME) *Includes but is not limited to crutches, braces, splints, and boots*	$20
Hearing Exams	$0
Hearing Aid *Participant only benefit; every five years*	$150 per aide
Internal Lab and/or X-Ray orders *Ordered by wellness center providers*	$0
Outside Lab and/or X-Ray orders *When a patient is <u>not</u> a primary care patient with a wellness center provider, lab appointments and X-Rays performed will incur a fee for service when ordered by an outside provider. All outside lab and X-Ray orders must be reviewed for complexity prior to scheduling*	$20
Fees for No Shows *"No Show" refers to a patient with a scheduled appointment who does not contact the wellness at least 10 minutes prior to and misses the appointment (more than 10 minutes late).*	$20
PHARMACY	
All Formulary Medication Prescriptions *A formulary is the list of generic and brand-name prescription drugs covered under the health plan.*	$0
Non-Formulary Medication Prescriptions *Prescription drugs that are not covered under the health plan because an alternative is proven to be just as effective, safe and less costly.*	Medication cost
VISION	
Comprehensive Eye Exam	$0
Pre-Testing and Retinal Imaging	$0
Frames *Every 24 months*	$0 *You pay 20% of balance > $150* *Or > $170 for Brand*
Lenses *Every calendar year*	$0

Schedule updated 20221208

Lens Enhancements *Every calendar year* Standard Progressive Premium Progressive Custom Progressive	 *You pay balance* Plan pays $50 Plan pays $80-90 Plan pays $120-160
Contacts instead of glasses *Every calendar year*	$0
Contacts, elective *Every calendar year*	*You pay balance* Plan pays $150
Safety frames, standard lenses included *Participant only benefit, every 24 months*	$25