St. Louis-Kansas City Carpenters Regional Health Plan - *Premium Plan*
Medical, Prescription, Dental & Vision Schedule of Benefits as of 5/1/23

CARPENTERS BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

Premium Medical Schedule of Benefits

BENEFIT	UHC Choice Plus In-Network	Out-of-Network Providers Premium Plan Only
Annual Deductible – Participant Responsibility	$300 Individual/$900 Family	$2,000 Individual/$6,000 Family
Annual Out-Of-Pocket Maximum – Participant Responsibility	$2,800 Individual/$8,400 Family	$90,000 Ind/Unlimited Family
Coinsurance – Participant Responsibility	20%	50%
PREVENTIVE CARE		
Routine Preventive Care	Plan Pays 100% Participant Pays 0%	Plan Pays 50% Participant Pays OON Deductible & 50% Coinsurance
Routine Mammogram	Plan Pays 100% Participant Pays 0%	Plan Pays 50% Participant Pays OON Deductible & 50% Coinsurance
Routine Colonoscopy	Plan Pays 100% Participant Pays 0%	Plan Pays 50% Participant Pays OON Deductible & 50% Coinsurance
OFFICE VISITS – NON-ROUTINE	***Participant Pays***	
Primary Care Physician Office Visit	$25 Copay	OON Deductible & 50%
Specialist Office Visit	$50 Copay	OON Deductible & 50%
Mental Health and Substance Abuse Office Visit	$25 Copay	OON Deductible & 50%
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	Not Covered
OUTPATIENT SERVICES[1]	***Participant Pays***	
Outpatient Surgery[1, 4]	INN Deductible & 20%	OON Deductible & 50%
Hearing Aid Participant only benefit limited to $2,000 per ear every 5 years.	INN Deductible & 20%	Same as In-Network
Lab LabCorp and Quest Diagnostics Outpatient facilities for labs means an outpatient hospital-owned lab.	LabCorp / Quest: $0 Copay, No Deductible Outpatient Lab: INN Deductible & 20%	OON Deductible & 50%
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: INN Deductible & 20%	OON Deductible & 50%
Physical, Speech and Occupational Therapy Limited to combination of 60 visits annually.	$25 Copay	OON Deductible & 50%
All other therapies – Includes Cognitive Therapy and Pulmonary Rehab Limited to combination of 60 visits annually.	INN Deductible & 20%	OON Deductible & 50%
Durable Medical Equipment, Orthotics and Prosthetics[1] Foot orthotics limited to $1,000 Annual Maximum.	INN Deductible & 20%	OON Deductible & 50%

BENEFIT	UHC Choice Plus In-Network	Out-of-Network Providers
	Participant Pays	
Breast Feeding Equipment and Supplies In-Network Purchase limited to one per live birth (single or multiple) with prior authorization. Includes related supplies. OON Rental limited to the rental of one breast pump per birth as ordered or prescribed by physicians. Includes related supplies.	Purchase ONLY: Participant Pays 0%	Rental ONLY: Participant Pays 0%
Home Health Services/ Hospice[1]	INN Deductible & 20%	OON Deductible & 50%
Outpatient Mental Health and Substance Abuse – All Other Services[1]	INN Deductible & 20%	OON 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.	$10 Copay	No Deductible, 50% coinsurance
INPATIENT SERVICES[1]	***Participant Pays***	
Inpatient Hospital Services[1, 4]	INN Deductible & 20%	OON Deductible & 50%
Convalescent Skilled Nursing Facility[1] Aggregate 100-day maximum cross accumulates among all benefit levels	INN Deductible & 20%	OON Deductible & 50%
Mental Health Substance and Abuse Residential Care[1]	INN Deductible & 20%	OON Deductible & 50%
Observation Room[1]	INN Deductible & 20%	OON Deductible & 50%
Physician Hospital Visits and Specialist Care/Consultations	INN Deductible & 20%	OON Deductible & 50%
Inpatient Ancillary Services (Emergency Room, Radiology, Anesthesiology, Pathology)	INN Deductible & 20%	OON Deductible & 50%
EMERGENCY AND URGENT CARE[2]	***Participant Pays***	
Hospital Emergency Room[2]	$250 Copay & 20% Coinsurance	Same as In-Network
Urgent Care Facility[3]	$75 Copay	OON Deductible & 50%
Ambulance Service - Ground	$150 Copay	Same as In-Network
Ambulance Service - Air	$1,000 Copay	Same as In-Network

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

[2]In the event a 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 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.

[3]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.

[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		
Family Annual Out-of-Pocket	$7,000		

[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 or Non-Network Providers.

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 *Participant Pays*	PREMIER NETWORK *Participant Pays*	NON-NETWORK[1] *Participant Pays*
Annual Deductible Preventive Services	$0	$50	$150
Annual Deductible All Other Services, Cumulative	$50	$75	$150
Preventive Services	0% Coinsurance	Deductible & 25%	Deductible & 50%
Basic Services	Deductible & 20%	Deductible & 50%	Deductible & 75%
Major Services	Deductible & 50%	Deductible & 60%	Deductible & 75%
Orthodontic Services	Deductible & 50%	Deductible & 50%	Deductible & 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

[1]When using a Non-Network Provider, usual and customary allowance is applied to the claim. The difference in what the dentist bills vs. the usual and customary allowable is the responsibility of the participant.
*Per Covered Person, age 19 and older. Maximum benefit for Basic and Major services do not apply to children 18 and younger.
**Refer to Section IV,C,3 of the Plan Document regarding definition and detailed information regarding Max Advantage.

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.

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
PREVENTIVE SERVICES cont.	
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.
Healthy Smiles, HealthyLives 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 bonemarrow 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.
BASIC BENEFITS	
Sealants	Applied to the occlusal surface of molars that are free from caries and restorations, once pertooth 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-operativecare.
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 toprosthetic appliances (bridgework and dentures).
MAJOR BENEFITS	
Prosthodontic Services	Services and appliances that replace missing natural teeth; includes fixed bridgework, partialdentures, 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), andjackets.
ORTHODONTIC BENEFITS	
Orthodontic Services	Services, treatment, and procedures required for the correction of malposed teeth.

Please refer to the 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 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.

VISION SERVICE OR SUPPLY	Frequency	Description	VSP Provider* *Participant Pays*	Non-VSP Provider Maximum Benefit*
Routine Eye Examination	*Every calendar year*	Focuses on overall eye wellness	$10 copay	Greater of $10 Copay or Balance after Plan Pays $38
PRESCRIPTION GLASSES				
Frames	*Every 24 months*	Included in Prescription Glasses	$25 Copay Plus 80% of Balance after Plan Pays $150	Greater of $25 Copay or Balance after Plan Pays $45
Lenses	*Every calendar year*	Single Vision	Plan Pays 100% No Participant copay	Plan Pays $31 Participant Pays Balance
		Lined bifocal	Plan Pays 100% No Participant copay	Plan Pays $51 Participant Pays Balance
		Lined trifocal	Plan Pays 100% No Participant copay	Plan Pays $64 Participant Pays Balance
		Lenticular	Plan Pays 100% No Participant copay	Plan Pays $80 Participant Pays Balance
Lens Enhancements	*Every calendar year*	Standard progressive	Plan Pays $50 Participant Pays Balance	Not covered
		Premium progressive	Plan Pays $80 - $90 Participant Pays Balance	Not covered
		Custom progressive	Plan Pays $120 - $160 Participant Pays Balance	Not covered
Contacts (Instead of glasses)	*Every calendar year*	Medically necessary; prior authorization	Plan Pays 100% No Participant copay	Plan Pays $210 Participant Pays Balance
Contacts	*Every calendar year*	Elective	Plan Pays $150 (includes lens exam) Participant Pays Balance	Plan Pays $105 (does not include lens exam) Participant Pays Balance
PROTEC SAFETY® (Active Participant-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	$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

**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.*

Short-Term Disability Benefits

The Plan provides an ancillary benefit to assist Members who are unable to work during periods of temporary Disability. 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 may be eligible to receive short-term disability benefits. Members *excluded* from short-term disability coverage include participants under the Basic Plan, participants covered under the Non-Bargained Office Employee group, and participants with COBRA coverage.

Both the member and physician must complete this form in order for the member to be considered for weekly benefits due to a non-work-related accident/illness. The Member must be in direct care of a Physician who certifies the member is Disabled and states an expected return to work date.

BENEFIT	**AMOUNT** ***Plan Pays***
Short-Term Disability (weekly indemnity)	$300 per week

Please refer to the Health Plan Document for detailed information.

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 – Premium Plan
Carpenters Wellness Center Schedule of Benefits as of 5/1/2023

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 20230626

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