SUMMARY PLAN DESCRIPTION

EFFECTIVE MAY 1, 2024

Plan Document and Summary Plan Description
St. Louis-Kansas City Carpenters Regional Health Plan

RESTATED AS OF:

May 1, 2024

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. 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.

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

Below is key information about this Plan:

- The name of the Plan is the St. Louis-Kansas City Carpenters Regional Health Plan.
- The Plan Sponsor and Plan Administrator are the Board of Trustees of St. Louis-Kansas City Carpenters Regional Health Plan.
- 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@laborfunds.org

- 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, Member Assistance Program (MAP) and Safety Enhancement.
- 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.
- 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.

- The Plan is established and maintained pursuant to Collective Bargaining Agreements and participation agreements between Employers and the Mid-America Carpenters Regional Council. Contributions are made to the Fund by participating Employers for active Participants. Pursuant to the terms set forth in Section I, the Plan permits self-payments by underemployed, retired, disabled, and Self-Employed Participants and Surviving Spouses, as well as COBRA continuation Premiums.
- 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 Participants 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.

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SECTION I
ELIGIBILITY & ENROLLMENT

Section I – Eligibility & Enrollment

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ELIGIBILITY & ENROLLMENT

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

A. ELIGIBLE GROUPS

Individual eligibility requirements vary by applicable group, as described below.

1. **Bargained Employees** covered by a Collective Bargaining Agreement requiring contributions to this Plan.

2. **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 monthly contributions to this Plan; and
      a) The Employer must either:
         i. Have at least one employee regularly employed who is covered by the Employer's Collective Bargaining Agreement, or
         ii. 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 the applicable monthly premium and 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 IRC Code, and at the employer's option, may also agree to contribute for all such employees who work fewer hours than specified above.

   (e) Non-Bargained Office Employee coverage for any or all Employers may be terminated by the Trustees at any time.

3. **Non-Bargained In-House Employees,** who are Employees of the following Employers, where a Participation Agreement has been signed and accepted by the Trustees where monthly contributions are required to this Plan:

   (a) Employees of the Mid-America Carpenters Regional Benefit Services, Inc.,
   (b) Employees of Mid-America Carpenters Regional Council working as part of the regions

covered by this Plan, and

(c) Employees of the Mid-America Carpenters Regional Council Apprentice and Training Centers working as part of the regions covered by this Plan.

4. **Retired Employees** who were covered as a Bargained Employee or Non-Bargained In-House Employee and are making self-pay contributions to the Plan.

5. **Other individuals** or groups are subject to Trustee approval.

B. APPLICABLE BENEFIT PLAN

Premium Plan

All eligible Participants, other than those described below, are enrolled as a Participant in the Premium Benefit Plan as outlined in Section II and further explained in detail by coverage in other sections.

Basic Plan

Bargained Employees, who meet Initial Eligibility for the first time in the Active Classification on or after July 1, 2023, and are determined, as applicable, by the Regional Council or Apprentice and Training Fund or its successor to be a First, Second, Third or Fourth Term Apprentice, will be enrolled as a Participant in the Basic Benefit Plan as outlined in Section II and further explained in detail by coverage in other sections.

Once a Bargained Employee in the Basic Plan is upgraded to Fifth Term Apprentice status as determined by the Regional Council or Apprentice and Training Fund or its successor, the Employee will be moved to the Premium Plan on the date the Plan is notified of this upgrade. Once upgraded to the Premium Plan, a Bargained Employee will remain in the Premium Plan.

C. ELIGIBILITY CLASSIFICATIONS

1. **Active Classification**

A Participant is in the Active Classification if eligibility results from:

- Employer contributions in accordance with signatory Collective Bargaining Agreements,
- Employer contributions in accordance with group Participation Agreements,
- Minimum/Difference self-payments,
- COBRA self-payments, or
- Participant's Self-Employed contribution (closed group).

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

There are two Eligibility Classes under the Active Classification:

1) Hours-Based Eligibility is composed of Bargained Employees and Grandfathered In-House Employees who receive Credit Hours by a Signatory Employer with a Collective Bargaining Agreement or an Employer with a Participation Agreement.

2) Monthly Eligibility is composed of Non-Bargained Office Employees and Non-Bargained In-House Employees with respect to whom a monthly Employer contribution is required and received, or Employees who are Self-Employed individuals (closed group) with respect to whom monthly Self-Employed contribution is required and received.

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

a) Hours-Based Eligibility

a) For continuing Hours-Based Eligibility, the Plan has the concepts of fiscal Contribution Quarters and calendar year Benefit Quarters.

Continuing Hours-Based Eligibility		
CONTRIBUTION QUARTERS (When hours are worked)	***Two-Month Processing Period***	***BENEFIT QUARTERS (When coverage is granted)***
May, Jun, Jul	Aug, Sep	Oct, Nov, Dec
Aug, Sep, Oct	Nov, Dec	Jan, Feb, Mar
Nov, Dec, Jan	Feb, Mar	Apr, May, Jun
Feb, Mar, Apr	May, Jun	Jul, Aug, Sep

Initial eligibility requires working 300 Credit Hours in a rolling three-month period. However, for initial coverage in the Plan, known as **Initial Eligibility**, the first two Benefit Quarters of coverage are based on a rolling three-month period instead of the Contribution Quarter/Benefit Quarter schedule above. This allows immediate coverage without the two-month processing period.

This Initial Eligibility rule will be applied to grant coverage for the first two Benefit Quarters by continuing to work an average of 300 hours within a rolling three-month period. For the third Benefit Quarter, you must meet the Continuing Eligibility rules explained later in this section.

Bargained Employees initially become eligible for benefits in the Hours-Based Eligibility Class on the first day of the month immediately following the completion of 300 Credit Hours within three months or less. Initial Coverage is extended for the immediate next three months.

To meet the Initial Eligibility test criteria, Credit Hours will only count if the participant has not been covered in any Active Eligibility class for the previous 24 months.

Below are examples of how coverage begins using the rolling three-month Initial Eligibility rule.

Example #1: 300 Credit Hours in each of the three-month periods		
Rolling Three-Month Periods starting in May:		**IMMEDIATE Coverage Earned Extended until the end of the 2nd Calendar Benefit Quarter**
May **June** **July**	100 hours 100 hours 100 hours = 300 hours	**Earns coverage for August, September, October**
June **July** **August**	100 hours 100 hours 100 hours = 300 hours	**Earns coverage for September, October, November (Adds November)**
July **August** **September**	100 hours 100 hours 100 hours = 300 hours	**Earns coverage for October, November, December (Adds December)** **End of the 2nd Benefit Quarter**

Example #2: 300 Credit Hours in first two months of work with a couple of months of lower work months but continuing to work an average of 300 hours to have coverage for the first two Benefit Quarters		
Rolling Three Month Periods starting in June		**IMMEDIATE Coverage Earned Extended until the end of the 2nd Calendar Benefit Quarter**
June **July**	150 hours 150 hours = 300 hours	**Earns coverage for August, September, October**
July **August** **Sept**	150 hours 75 hours 50 hours = 275 hours	**No additional coverage earned**
August **September** **October**	75 hours 50 hours 175 hours = 300 hours	**Earns coverage for November, December (Adds November and December)** **End of the 2nd Benefit Quarter**

b) Other Memorandum of Agreement in the Hours-Based Eligibility Class. An Employee of a Signatory Employer may be given Immediate Health Benefits Eligibility for a limited period of time by receiving the applicable contributions for such immediate coverage as approved by the Regional Council and the Trustees.

b) Monthly Eligibility

Non-Bargained Office Employees, Non-Bargained In-House Employees and other groups in the Monthly Eligibility class becomes eligible for benefits on the first day of the month following the month in which the first timely contribution is received and paid.

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

Once Initial Eligibility is reached, a participant may continue coverage by meeting one of the following Continuing Eligibility rules:

a) Hours-Based Eligibility Class:

a) Quarterly Rule:

330 Credit Hours in a Contribution Quarter starting with May 1, 2024, will extend eligibility through the Benefit Quarter that next follows that Contribution Quarter as below:

CONTRIBUTION QUARTERS Effective May 1, 2024 (When hours are worked)	*Hours Needed*	*Two-Month Processing Period*	*BENEFIT QUARTERS (When coverage is granted)*
May **June** **July**	330	August September	October November December
August **September** **October**	330	November December	January February March
November **December** **January**	330	February March	April May June
February **March** **April**	330	May June	July August September

b) Look Back Rule: A member who works at least 1440 credit hours during the four (4) previous Contribution Quarters (12 months), will have eligibility extended through the Benefit Quarter that next follows that Contribution Quarter.

FOUR CONTRIBUTION QUARTERS (When hours are worked)	*Hours Needed*	*Two-Month Processing Period*	*BENEFIT QUARTERS (When coverage is granted)*
May - April	1,440	May June	July August September
August – July	1,440	August September	October November December
November – October	1,440	November December	January February March
February - January	1,440	February March	April May June

c) Plan Year Rule: A member who works at least 1560 uncapped credit hours whose employer contributes the full, unsubsidized Journeyman rate for health and welfare benefits in a Plan Year (May 1 - April 30), will have eligibility extended from July 1 through December 31 of the same year, or six months of coverage.

Plan Year (When hours are worked)	*Full Credit Hours Needed*	*Two-Month Processing Period*	*BENEFIT QUARTERS (When coverage is granted)*
May - April	1,560	May June	July to December

d) Extension of Hours-Based Eligibility for Disability: If a Participant 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 1,440 Credit Hours during the 12 consecutive months ending with the month in which the Total Disability began, the Participant's eligibility in the Hours-Based Eligibility Class will be automatically continued, without contributions, until the earlier of:

i. The end of the Benefit Quarter associated with the Contribution Quarter in which the Participant's Total Disability ends,
ii. The end of the Benefit Quarter associated with the Contribution Quarter in which the Participant returns to work, or
iii. The end of the Benefit Quarter contains the first anniversary of the date the Participant's Total Disability began.

b) Monthly Eligibility Class

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

(d) **Termination of Active Classification Coverage**

Notwithstanding any provision herein to the contrary, the Participant's coverage and benefits will end on the earliest of the following dates unless the Participant is eligible for and has elected to continue coverage under one of the Self-Pay Provisions:

a) The last day of eligibility earned by the Participant's Credit Hours, monthly self-payment, or monthly Employer contribution.

b) The date the Participant is found to have engaged in employment in the construction industry by an Employer who is not obligated to contribute to the Plan. (This is not a COBRA qualifying event.)

c) The date of the Participant's death.

d) The date the Participant falsifies any information in connection with coverage, a claim for benefits or commits any action with the intent to defraud the Plan. (This is not a COBRA qualifying event.)

e) The date the Participant is eligible for Medicare that is primary to the Plan, but is not enrolled in both Medicare Part A and B. An Active Classification Participant Medicare coverage is primary to this Plan if:

a) The date a Non-Bargained Office Employee is employed by a "Small Employer" within the meaning of the Medicare regulations and is eligible for Medicare due to age, or

b) The date Medicare is primary after the Participant had 30 months of secondary Medicare coverage on account of End-Stage Renal Disease, except if the Participant's eligibility is based on COBRA continuation coverage.

f) The date the Participant's Employer is no longer obligated to contribute to this Plan. (This is not a COBRA qualifying event.)

g) The date the Plan terminates.

Eligibility of the Participant 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 Subsection F of this Section.

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

A Participant who has lost coverage and acquired a gap in coverage may meet one of the following requirements:

a) Hours-Based Eligibility Class: The Participant must work the required number of Credit Hours in a Contribution Quarter under the Continuing Eligibility rules, provided these Credit Hours are worked within 24 months of the Participant's Hours-Based Eligibility termination date. The reinstated coverage becomes effective on the first day of the next Benefit Quarter. Once a Participant loses Hours-Based Eligibility for a period of 24 months or more, the Initial Eligibility rule will be required to re-establish coverage upon or after the 25th month.

b) Monthly Eligibility Class: A monthly contribution for such Participant is required, made, and received by the Employer. The Participant's coverage will be reinstated on the first day of the month following the month in which the contribution is received by the Plan.

(f) **Self-Payment Provisions applicable to Hours-Based Eligibility Class (Minimum/Difference Self-Payments)**

A Participant who is Bargained Employee or Grandfathered In-House Employee losing eligibility in the Active Classification may elect to maintain continuous Active Classification coverage by making a self-payment (Minimum/Difference payment). If a timely Minimum/Difference payment is paid for a Contribution Quarter, the Participant's eligibility will be extended for the next Benefit Quarter.

a) Excluded Participants:

a) Participants who are eligible for Medicare cannot begin a period of coverage by Minimum/Difference Payments. If the Participant becomes eligible for Medicare during a period of coverage by Minimum/Difference Payments, coverage will end at the end of the Benefit Quarter for which the payment was made.

a) Participants who have paid the maximum number of allowable Minimum/Difference payments.

b) Participants who are the owners, partners, 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 Participants 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.

c) Participants who have engaged in employment in the construction industry by an employer who is not obligated to contribute to this Plan.

d) Participants who are covered by COBRA continuation coverage.

b) Rate for Coverage:

The required payment amount is equal to the difference between 330 and the number of Credit Hours worked in the Contribution Quarter, multiplied by the Full Contribution Rate. If no Credit Hours were worked, the payment amount is equal to the full 330 hours.

c) Duration of Coverage:

Minimum/Difference payments can be paid for two Benefit Quarters within an 18-month period. These two payments can be consecutive.

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

a) The date the Participant's maximum period of Minimum/Difference coverage ends, and COBRA is not elected (if applicable);

b) The last day of the Benefit Quarter for which the Participant made a timely payment;

c) The end of the Benefit Quarter in which the Participant first becomes Eligible for Medicare;

d) The date the Participant has engaged in employment in the construction industry by an employer who is not obligated to contribute to this Plan;

e) The date of the Participant's death;

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

g) The date the Plan terminates.

d) Minimum/Difference and COBRA

Election of Minimum/Difference payments run concurrent with COBRA. If a Participant is losing Minimum/Difference coverage, COBRA continuation coverage will be offered for the balance of 18 months less the number of consecutive coverage months of Minimum/Difference payments. Once all Active Classification self-pay options are exhausted, the Participant can regain Hours-Based Eligibility by satisfying the Continuing Eligibility rules or Reinstatement Provisions. Alternatively, coverage may be maintained in the Non-Active Classification if the Participant qualifies.

e) Payment Due Date

The full payment amount is due on the first day of the month prior to the Benefit Quarter for coverage and must be received by the Fund within 30 days of the due date to be accepted. The payment schedule 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

2. **Non-Active Classification**

Bargained Employees, Non-Bargained In-House Employees, and Self-Employed Employees and their Dependents may continue coverage under the Plan through self-payments, after they no longer meet the requirements of the Active Classification. Participants must satisfy the additional requirements, set forth in this Subsections (c)-(h) below, of one of the following five categories:

- Retired Participant
- Retired Self-Employed Participant
- Non-Pension Participant

- Disabled Participant
- Surviving Spouse

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

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

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

If a Participant 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 (Participant 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 Participant enrolls in the UHC Medicare Advantage Program, the Participant 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.

b) Short-Term Disability Benefits

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

c) Dental Benefits

Participants covered in the Non-Active Classification, and Participants 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. Dental benefits must be elected for all covered under the medical coverage.

(b) **Dependent Coverage**

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

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

a) 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

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

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

Coverage of Participants 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 Benefit 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 (except Surviving Spouses and Non-Bargained In-House Employees), including Retired Self-Employed, Non-Pension and Disabled Participants, must maintain membership with the Mid-America Carpenters Regional Council or its affiliated Locals at all times to be eligible for Non-Active coverage.

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

As stated in this Subsection (a)(1) above, a Participant 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 & Medicare Part D 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 Participant's Dependent may participate in the UHC Medicare Advantage Program only if, and so long as, the Participant has elected family coverage.

While covered in the Active Classification, Participants 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 Participants**

For purposes of eligibility for coverage in the Non-Active Classification, a "retired Participant" 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 as a Bargained Participant with Hours-Based Eligibility or Non-Bargained In-House Participant, and (3) who is neither a retired Self-Employed Participant, a retired Non-Pension Participant, a Disabled Participant, nor a Surviving Spouse.

a) A Retired Participant first becomes eligible for Non-Active retiree coverage on the date the Participant begins to receive such pension benefits unless, on that date, the Participant is entitled to an additional period of Hours-Based, Monthly Eligibility or a prior election of Minimum/Difference or COBRA coverage. In such cases, the Retired Participant first becomes eligible for Non-Active retiree coverage at the end of such extended period of Active Classification coverage.

b) A Retired Participant can enroll in Non-Active retiree coverage only if:

    a) The Participant 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 Participant performed bargaining unit work for a Signatory Employer but was not required to contribute to this Plan, or

        2. Months of Active Classification coverage, excluding non-bargained Office Employee coverage, or

        3. Months of coverage in the Monthly Eligibility Class associated with Non-Bargained In-House Employees; and

    c) At least 36 months of said 120 months were earned during the 60 months immediately preceding election of Non-Active coverage.

c) A Bargained Participant who loses Active eligibility as a result of acquiring employment in a non-bargained position by a Signatory Employer, and who remains covered in a group health plan by that Signatory Employer during such employment, and who becomes a Retired Participant during or at the end of such employment, can enroll in

Non-Active retiree coverage only if:

a) The Participant elects such coverage within 63 days after losing coverage in the above-mentioned group health plan by that Signatory Employer: and

b) Has begun to receive pension benefits from any of the Carpenters' Pension Plans; and

c) Has at least 120 months, in any combination, of:

1. Months in which the Participant performed bargaining unit work for a Signatory Employer but was not required to contribute to this Plan, or

2. Months of Active Classification coverage, excluding non-bargained Office Employee coverage.

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

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

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

a) The Participant must attain age 55; and

b) The Participant must permanently cease all employment and inform the Plan in writing; and

c) The Participant must have at least 120 months in any combination of:

a. Months in which the Participant performed bargaining unit work for a Signatory Employer but was not required to contribute to this Plan, or

b. Months of Active Classification coverage, excluding non-bargained Office Employee coverage; and

d) At least 36 months of said 120 months were earned during the 60 months immediately preceding election of Non-Active coverage.

(h) **Disabled Participants**

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

a) A Participant first becomes eligible for Non-Active disabled coverage on the date the Participant becomes Totally and Permanently Disabled unless, on that date, the Participant 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 Participant first becomes eligible for Non-Active disabled coverage at the end of such extended period of Active Classification coverage; and

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

c) The Participant has at least 120 months, in any combination, of:

a) Months in which the Participant performed bargaining unit work for a Signatory Employer 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

d) At least 36 months of said 120 months were earned during the 60 months immediately preceding election of Non-Active coverage.

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

f) The Participant must provide medical evidence of Total and Permanent Disability as soon as reasonably possible after it becomes available to the Participant 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 Participant ceases to satisfy the requirements necessary to establish Total and Permanent Disability. However, if the participant is returning to covered employment, self-payments can be made during reinstatement into Active Classification as described in I(C)1.e above.

(i) **Surviving Spouse**

For purposes of eligibility for coverage in the Non-Active Classification, a "surviving spouse" is a Participant's Spouse who was covered as a Dependent at the time of the Participant's death. If the Participant was entitled to a period of Active coverage extending beyond the date of the Participant's death, the Surviving Spouse may maintain coverage for that period as the Participant's Dependent.

A Surviving Spouse is eligible to maintain coverage in this Plan when all the following conditions are met:

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

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

a) Months in which the Participant performed bargaining unit work for a Signatory Employer but not required to contribute to this Plan, or

b) Months of Active Classification coverage in the Hours-Based Eligibility Class including coverage by COBRA or Minimum/Difference payments; and

c) At least 36 months of said 120 months were earned during the 60 months immediately preceding election of Non-Active coverage; and

d) 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 Participant'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 Participant for purposes of the Plan.

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

Participants covered in the Non-Active Classification, other than disabled, retired Self-Employed, or non-Pension Participant, are not prohibited from receiving Employer contributions while working in covered employment in this Plan during Non-Active coverage. Participants 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. The credit or refund for hours worked in a month will not exceed the amount of the self-payment applicable for that benefit month.

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

1) The Participant must notify the Benefit Office in advance of the intent to have Credit Hours applied to reinstate Active Classification coverage, in which case Employer contributions for the Participant will cease to be credited against self-payments and will begin to be credited toward Active Classification eligibility.
2) If the loss of prior Active Classification coverage has not exceeded 24 months, the Participant must satisfy the Quarterly Eligibility rule within those 24 months to reestablish coverage, otherwise, the Participant must meet the Initial Eligibility rule.
3) Only Credit Hours earned during Non-Active coverage as provided above will be applied to satisfy eligibility requirements.
4) A Participant may move from Non-Active to Active coverage only once, except that a Participant 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 Classification Eligibility**

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

a) 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.
b) The date of the Participant's death.
c) The date the Participant falsifies any information in connection with coverage or a claim for benefits or commits any action with the intent to defraud the Plan.
d) The date the Participant is found to have engaged in employment in the construction industry by an Employer who is not obligated to contribute to the Plan.
e) The date the Plan terminates.

In addition, a Non-Active Participant's eligibility for all or most benefits in the Plan will end

on the date when the Participant 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 Participant's Dependents is determined by the same rules, regardless of whether the Participant has Active or Non-Active coverage. Coverage of Dependents of Participants 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 Participants in the Non-Active Classification are covered only if the Participant has elected family coverage at an increased Premium. A Medicare-eligible Dependent of a Non-Active Classification Participant may be covered for limited Plan benefits by enrolling in the Plan's Medicare Advantage program coverage at the applicable Premium, as described in Subsections 2(a)1) and 2(e) above. A Participant's Dependents are the Participant's Spouse and each Child of the Participant 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 Participant, or other person, is eligible as a Dependent regardless of financial support by the Participant.

1. **Initial Dependent Coverage**

   For all Eligibility Classes, initial coverage of a Participant's Dependents is derived from the Participant's eligibility. Coverage of a Dependent will begin when a Participant'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 (effective July 1, 2023, or 90 days in the case of a newborn 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 Participant, 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 Participant's Spouse is the individual to whom the Participant 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 Participant'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 Participants**

The Spouse of a Participant in the Active Classification will not be eligible as a Dependent unless the Participant 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 Participant'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 Participants 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.

In cases where Participants are given a stipend for health coverage by the employer who otherwise offers group coverage, a working Spouse is required to use the stipend to purchase health coverage that would be primary to this Plan.

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.

(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. Such verification may be requested at any time.

(g) **Failure to Enroll**

If a Participant's working Spouse fails to enroll in an employer-sponsored health plan when required, or if the Participant 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 Participant 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 Participant's "child" is any of the following, provided in each case that the child is a "Child" or "Dependent" of the Participant 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 Participant'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 Participant's stepchild provided the child's natural parent is the Participant's

Spouse.

(b) **Eligible Child**

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

(c) **Disabled Child**

A Participant'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 Participant is entitled to and does claim a deduction for the Child on the Participant's federal income tax return.

A Participant's Child is not eligible for Dependent coverage after age 26 unless, no later than 63 days after the Child's 26th birthday or the participant's eligibility date, whichever is later, and as often thereafter as requested by the Plan, the Participant 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 future 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 aged 18 or older or a Spouse must request to opt out of the Plan individually.

5. **Special Enrollment**

The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 added the following special enrollment rights applicable to group health plans. By law, the Plan must provide the following description of special enrollment rights to anyone who is not enrolled in the Plan but later becomes eligible for coverage, even though it is doubtful these rights would affect you or your Dependents since coverage under this Plan is automatic for you and your Dependents once you establish eligibility:

(a) You and your Dependents may also enroll in the Plan if you (or your Dependent) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

(b) You and your Dependents may also enroll in this Plan if you (or your Dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your Dependents) are determined to be eligible for such assistance.

6. **Termination of Dependent Eligibility**

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

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

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

(b) In the event of the death of a Participant while covered in the Hours-Based Eligibility Class, the Participant's Dependents (including Step-Children) 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 Participant'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 the 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 Dependent's Medicare coverage is primary to this Plan if:

1) The date a Dependent of Non-Bargained Office Employee is employed by a "Small Employer" within the meaning of the Medicare regulations and is eligible for Medicare due to age, or

2) The date Medicare is primary after the Dependent had 30 months of secondary Medicare coverage on account of End-Stage Renal Disease except if the Dependent's eligibility is based on COBRA coverage.

(e) The date the Participant 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 a Qualifying Event is eligible to elect COBRA continuation coverage. An Active Participant 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 Participant reestablishes eligibility as provided in the Plan.

Unlike most other coverage under the Plan, each individual Participant and Dependent who is a Qualified Beneficiary is entitled to make an independent 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 Participant's hours of employment; or

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

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

   (d) Death of a Participant; or

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

   (f) A Participant becoming Entitled to Medicare; or

   (g) A Child attaining age 26, or otherwise ceasing to qualify as a Participant'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 Participant eligible in the Active Classification; or

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

   (c) A child born to or placed for adoption with Participant 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 Participant can be a Qualified Beneficiary only with respect to termination or reduction in hours of the Participant's employment, bankruptcy of the Participant's Employer, or the Participant 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 Participant's continuation coverage ends before the end of the maximum period. Although a child born to or placed for adoption with a Participant 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 Participant after a qualifying event, or a person who becomes the spouse of a Qualified Beneficiary (regardless of whether the Qualified Beneficiary is the Participant) 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 Participants. 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 Participant's divorce or legal separation, or because of a Participant'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 sometime 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 Participant 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 (or less if reduced by Minimum/Difference payments) after the date of the Qualifying Event unless extended for one of the following reasons:

a) **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.

b) Medicare Entitlement

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

c) 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 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.

(d) 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. MILITARY LEAVE

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 Participant 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 Participant'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 Subsection E of this Section.

This section provides a summary of a Participant'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 Participants, or duty performed by intermittent disaster response personnel for the Public Health Service.

Eligibility Frozen

If you lose eligibility due to service in the Uniformed Services, your eligibility remaining at the time of activation for service may be frozen or suspended until you return from such service and elect to reinstate coverage under the Plan. For service in the Uniformed Services of 31 days or more, but less than 181 days, an application for re-employment with a Contributing Employer must be filed within 14 calendar days (not workdays) after your release from such service. For service in the Uniformed Services over 181 days, an application for re-employment must be submitted within 90 calendar days (not workdays) after an honorable discharge from such service. Upon discharge from service in the Uniformed Services, frozen eligibility (if any) for you and your Dependents will be reinstated on the date that you return to work with a Contributing Employer, provided such return to work is within the deadline stated above. If you do not return to work with a Contributing Employer within 90 days of your separation from such service, you may regain eligibility upon meeting the initial eligibility requirement set forth in Section I.

USERRA Continuation Coverage

You may also make self-payments for up to 24 months pursuant to USERRA pursuant to the rules and procedures set forth below. However, you will not accumulate any additional eligibility during the time you are absent for such service, and an election to make self-payments to continue coverage during the time of such service (for a period of up to 24 months) will not result in the accumulation of any additional eligibility.

Notice Required

You must notify the Benefit Office immediately when you know you are entering service in the Uniformed Services. If notification to the Benefit Office is delayed, the extension of coverage for a maximum of 24 months still begins with the initial date of entry into service in the Uniformed Services and a retroactive payment to that date may be charged. You have an obligation to notify the Benefit Office as soon as you know you are entering such Uniformed Service if you wish to take advantage of USERRA Continuation Coverage. Failure to notify the Benefit Office may be taken as an indication that you do not wish to purchase coverage for you or your Dependents.

Period of USERRA Continuation Coverage

The period during which a Participant 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 Participant 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 Participant'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 Participant or termination of the plan).

Cost of USERRA Continuation Coverage

A Participant who has established eligibility for coverage based on hours in accordance with Section 1 may elect to continue coverage under USERRA until the expiration of such eligibility. If eligibility is exhausted, or the Participant 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 Participant for coverage will be determined as follows:

a. If the Participant is absent from covered employment for less than 31 days, he or she must pay the regular cost of coverage for a Participant under the Plan.
b. If the Participant 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.

SECTION II
SCHEDULE OF BENEFITS

Section II – Schedule of Benefits

This section contains a summary of benefits for the following:

A. Premium Plan Schedule of Benefit…… II-1

B. Basic Plan Schedule of Benefits…… II-10

C. Wellness Center Schedule of Benefits…….... II-16

These summaries highlight provisions of the plan. Later sections in this booklet describe each benefit in more detail. In the event of any conflict of these summaries and the actual plan terms, the actual plan terms apply.

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

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] Independently owned, freestanding imaging facilities (not hospital or physician group owned). Facility for radiology means an outpatient hospital system-owned radiology center.	Independently owned, freestanding imaging facilities (not hospital or physician group owned): $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%

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

Medical Schedule of Benefits

BENEFIT	UHC Choice Plus In-Network	Out-of-Network Providers
	Participant Pays	
Breast Feeding Equipment and Supplies Purchase limited to one per live birth (single or multiple) with prior authorization. Includes related supplies. Rental limited to the rental of one breast pump per birth as ordered or prescribed by physicians with prior authorization, includes related supplies	Participant Pays 0%	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 If Not Enrolled in SaveOnSP Program: *Select Specialty Drugs may be found on the SaveonSP Specialty Drug list:* www.saveonsp.com/carpdc	$0 No MAX		0% 30% Minimum *If not enrolled in SaveonSP* *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/90-day 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 VI-D of the Plan Document regarding definition and detailed information regarding Max Advantage.

Dental Schedule of Benefits, cont.

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.
Radiographs	X-rays as required or in conjunction with the diagnosis of a specific condition. • Bite-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 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 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).

Dental Schedule of Benefits, cont.

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.

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.

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 24months*	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

Vision Schedule of Benefits, cont.

PROTEC SAFETY (Active Participant-Only Coverage) with VSP Provider Only				
Frames	*Every 24months*	VSP doctor's ProTec Eyewear® collection Certified according to the ANSI guidelines for impact protection	$25 Copay	Not covered
Lenses	*Every 24months*	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 Participants who are unable to work during periods of temporary Disability. A Participant in the Active Classification who becomes temporarily Disabled because of a non-occupational accident or Illness that occurs while eligible for medical benefits in the Plan may be eligible to receive short-term disability benefits. Participants 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 Participant and physician must complete this form in order for the Participant to be considered for weekly benefits due to a non-work-related accident/Illness. The Participant must be in direct care of a Physician who certifies the Participant is Disabled and states an expected return to work date.

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

Life Insurance Benefits

The Plan provides Life and Accidental Death and Dismemberment (AD&D) benefits under policies insured by a commercial insurance company. A Participant is eligible for Life insurance and AD&D benefits so long as the Participant 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 Participant	$8,000
Insurance on Life of eligible Dependent	$2,000
AD&D death benefit (Participants 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-KANASAS CITY CARPENTERS REGIONAL HEALTH PLAN – BASIC PLAN - MEDICAL, PRESCRIPTION, DENTAL & VISION (Schedule of Benefits as of 7/1/23)

Medical Benefits: Basic Plan

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 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.	$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] Independently owned, freestanding imaging facilities (not hospital or physician group owned). Facility for radiology means an outpatient hospital system-owned radiology center.	Independently owned, freestanding imaging facilities (not hospital or physician group owned): $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%

Medical Benefits – Basic Plan, cont.

BENEFIT	UHC Choice Plus In-Network Coverage Only *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%
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%.

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

Prescription Schedule of Benefits

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: Basic Plan

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.

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

Dental Schedule of Benefits, cont.

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. • Bite-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 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 applications are covered twice per calendar year.

Please refer to Section IV 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 Participant is eligible for Life insurance and AD&D benefits so long as the Participant 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 Participant	$8,000
Insurance on Life of eligible Dependent	$2,000
AD&D death benefit (Participant 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%*

Wellness Center Schedule of Benefits: St. Louis Location

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
DENTAL	
Preventive Services	$0
Basic Services	$0
Major Services *Includes restorative and prosthodontic services requiring lab work*	Refer to Carpenters Dental Center fee schedule

Wellness Center Schedule of Benefits, cont.

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
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

SECTION III
MEDICAL BENEFITS

Section III – Medical Benefits

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MEDICAL BENEFITS

A. DETAILED 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 Illness, or to maintain wellness. The Medical Benefit does not cover prescription drugs, vision care or dental care, each of which is covered by a separate benefit and Section.

Benefits listed in the overview and detailed list of benefits, effective May 1, 2023, are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

In addition to the benefits outlined below, please refer to the Wellness Center Benefits section of this SPD to understand the list of benefits available for care received at the Wellness Center.

Below is a summary of the Premium Plan of medical benefits. The SPD also includes a summarized schedule of benefits.

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Copays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Medical Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

B. DETAILED PREMIUM MEDICAL PLAN

PREMIUM MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Annual Deductible Per Calendar Year Excluding Prescription Benefit Deductible: • Per Person • Per Family – Individual Embedded Deductible **Note: Embedded deductible means that if you have family coverage, any combination of covered family participants may help meet the maximum family deductible; however, no one person will pay more than their embedded Individual deductible amount.**	 $300 $900 $300	 $2,000 $6,000 $2,000
Plan Coinsurance Rate, Unless Otherwise Stated Below: • Paid By Plan after Participant Satisfaction of Deductible • Paid by Participant	 80% 20%	 50% 50%
Annual Total Out-Of-Pocket Maximum for Medical Excluding Prescription Benefit Out-Of-Pocket Maximum: • Per Person • Per Family – Individual Embedded Out-Of-Pocket Maximum **Note: Embedded out-of-pocket maximum means that if you have family coverage, any combination of covered family participants may help meet the family out-of- pocket maximum; however, no one person will pay more than their embedded individual out-of-pocket maximum amount.** **Out-Of-Pocket Maximum includes the applicable deductible, participant coinsurance and any copays.**	 $2,800 $8,400 $2,800	 $90,000 Unlimited $90,000

Below are more details about the Premium Plan coverage, effective May 1, 2023. Some services subject to a copay may have a waiver of deductible. Also, the Schedule of Benefits summarizes the Premium Plan including medical, prescription, dental and vision. In situations where the deductible is waived, it is indicated. Otherwise, your coinsurance applies after you have met the annual deductible.

PREMIUM MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Ambulance Transportation		
Ground:		
• Copay Per Trip	$150	$150
• Coinsurance	0% (Deductible Waived)	0% (Deductible Waived)
Air:		
• Copay Per Trip	$1,000	$1,000
• Coinsurance	0% (Deductible Waived)	0% (Deductible Waived)
Breast Pumps		
• Maximum Benefit Per Birth	Provides for rental, and if not available, purchase of 1 Breast Pump, subject to cost-effective UMR review process	Only covered in the event that in-network not available.
• Coinsurance	0%	
• Paid By Plan	100% (Deductible Waived)	
Cardiac Pulmonary Rehabilitation		
• Maximum Days Per Calendar Year	60 Days	
• Coinsurance after Deductible met	20%	50%
Cardiac Rehabilitation Phase 1 & 2		
• Maximum Days Per Calendar Year	60 Days	
• Coinsurance after Deductible met	20%	50%
Chiropractic Services		
• Copay Per Visit	$10	Not Applicable
• Maximum Visits Per Calendar Year	40 Visits	
• Coinsurance after Copay	0% (Deductible Waived)	50% (Deductible Waived)
Visit maximums are applied based on provider designation and procedure code. If a provider bills for a manipulation and a therapy on the same claim, only one visit will be applied to the manipulation maximum based on the provider's designation.		

PREMIUM MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Cognitive Rehabilitation • Maximum Days Per Calendar Year • Coinsurance after Deductible met	60 Days 20%	50%
Contraceptive Methods and Contraceptive Counseling Approved by the FDA **For Men:** • Coinsurance after Deductible met **For Women:** • Coinsurance after Deductible met	20% 0% (Deductible Waved)	50% 50%
Counseling Services **Nutritional:** • Maximum Visits Per Calendar Year • Coinsurance after Deductible met **Note: Mental Health and Substance Abuse conditions are excluded from the maximum.**	3 Visits 20%	50%
Durable Medical Equipment • Coinsurance after Deductible met	20%	50%
Emergency Services / Treatment **Urgent Care:** • Copay Per Visit • Coinsurance after Copay/Deductible **Walk-In Retail Health Clinics:** • Copay Per Visit • Coinsurance after Copay/Deductible **Emergency Room Only (includes Physician and Facility charges):** • Copay Per Visit including any continuous Observation (but less than 72 hours) that is part of the ER Visit and prior to any admission • Coinsurance after Copay If Admitted Inpatient within 24 Hour(s) of initial ER Visit or after the Emergency Room visit and a period of continuous Observation that is less than 72 hours	**$75** 0% (Deductible Waived) **$25** 0% (Deductible Waived) **$250 Copay** **20%** Copay waived; 20% after deductible	Not Applicable 50% Not Applicable 50% **$250 Copay** 20% Copay waived; 20% after deductible
Extended Care Facility Benefits, Such as Skilled Nursing, Convalescent, or Subacute Facility • Maximum Days Per Calendar Year • Coinsurance after Deductible met	100 Days 20%	50%

PREMIUM MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Preventive / Routine Care Benefits. See Glossary of Terms for Definition.		
Benefits Include:		
Preventive / Routine Physical Exams at Appropriate Ages:		
• Maximum Exams Per Calendar Year	1 Exam	
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Immunizations:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Note: Foreign Travel Immunizations will not be covered.		
Preventive / Routine Diagnostic Tests, Lab, and X- Rays at Appropriate Ages:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Preventive / Routine Mammograms and Breast Exams:		
From Age 35 to Age 39		
• Maximum Exams Including 3D Mammograms for Preventive Screenings	1 Exam	1 Exam
From Age 40		
• Maximum Exams Per Calendar Year Including 3D Mammograms for Preventive Screenings	1 Exam	1 Exam
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
3D Mammograms for Preventive Screenings:		
Included in Preventive / Routine Mammograms and Breast Exams Maximum		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
3D Mammograms for Diagnosis / Treatment of a Covered Medical Benefit:		
• Coinsurance after Deductible met	20%	50%
Preventive / Routine Pelvic Exams and Pap Tests:		
• Maximum Exams Per Calendar Year	1 exam	1 exam
• Coinsurance after Deductible met	(Deductible waived)	50%

PREMIUM MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Preventive / Routine PSA Test and Prostate Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Preventive / Routine Screenings / Services at Appropriate Ages and Gender:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Preventive / Routine Colonoscopies, Sigmoidoscopies, and Similar Routine Surgical Procedures Performed for Preventive Reasons: From Age 45		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Preventive / Routine Counseling for Alcohol or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, and Nutrition:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Preventive / Routine Hearing Exams:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
In Addition, the following Preventive / Routine Services are Covered for Women: ➢ Screening for Gestational Diabetes ➢ Papillomavirus DNA Testing* ➢ Counseling for Sexually Transmitted Infections (Provided Annually)* ➢ Counseling for Human Immune-Deficiency Virus (Provided Annually)* ➢ Breastfeeding Support, Supplies, And Counseling ➢ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
***These Services may also apply to men.**		

PREMIUM MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Preventive / Routine Care Benefits for Children Include:		
Preventive / Routine Physical Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Immunizations:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Note: Foreign travel immunizations will not be covered.		
Preventive / Routine Screenings at Appropriate Ages:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Preventive / Routine Autism Screening:		
From Age 18 Months To 24 Months	0%	50%
• Coinsurance after Deductible met		
Preventive / Routine Diagnostic Tests, Lab, and X- Rays:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Preventive / Routine Hearing Exams:		
• Coinsurance after Deductible met	0% (Deductible Waived	50%
Sterilizations:		
For Men:		
• Coinsurance after Deductible met	20%	50%
For Women:		
• Coinsurance after Deductible met	0% (Deductible Waived)	50%
Teladoc Services		
General Medicine:		
• Coinsurance	0% (Deductible Waived)	
Behavioral Health:		
• Coinsurance	0% (Deductible Waived)	
Telehealth		
• Copay Per Visit - Primary Care Physician	$25	Not Applicable
• Copay Per Visit - Specialist	$50	Not Applicable
• Coinsurance after Deductible met	0% (Deductible Waived)	50%

TRANSPLANT SCHEDULE OF BENEFITS **The program for Transplant Services at Designated Transplant Facilities is: Optum Premium Medical Plan**	
Transplant Services at Designated Transplant Facility **Transplant Services:** • Coinsurance after Deductible met **Travel and housing:** • Maximum Benefit Per Transplant • Minimum Benefit Per Day • Coinsurance Travel and housing at designated transplant facility at contract effective date/pre-transplant evaluation and up to one year from date of transplant. ***Note: Lodging amounts exceeding the limit are the covered person's responsibility. Air travel is limited to the transplant covered person, plus one other person or for both parents if for child transplant covered participant.***	 20% $10,000 $50 up to $100 for two people, including the transplant recipient 0% (Deductible Waived)

C. DETAILED BASIC MEDICAL PLAN

For certain apprentice eligibility classes, the Basic Plan applies and includes the following provisions.

With respect to the Basic Medical Plan, the same covered services are included using UHC's Choice Plus network, but the deductible, coinsurance and out of pocket maximums are increased. No out of network coverage is available, except for certain emergency services and other claims subject to the No Surprises Act under which any out of network treatment is considered as in network.

In addition to the benefits outlined below, please refer to the Wellness Center Benefits section of this SPD to understand the list of benefits available for care received at the Wellness Center.

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Annual Deductible Per Calendar Year Excluding Prescription Benefit Deductible: • Per Person • Per Family – Individual Embedded Deductible ***Note: Embedded deductible means that if you have family coverage, any combination of covered family participants may help meet the maximum family deductible; however, no one person will pay more than their embedded individual deductible amount.***	$1,000 $3,000 $1,000	Not covered
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan after Participant Satisfaction of Deductible • Paid by Participant	70% 30%	Not covered
Annual Total Out-Of-Pocket Maximum Excluding Prescription Benefit Out-Of-Pocket Maximum: • Per Person • Per Family – Individual Embedded Out-Of-Pocket Maximum ***Note: Embedded out-of-pocket maximum means that if you have family coverage, any combination of covered family participants may help meet the family out-of-pocket maximum; however, no one person will pay more than their embedded individual out-of-pocket maximum amount.*** **Out-Of-Pocket Maximum includes the applicable deductible, participant coinsurance and any copays.**	$5,600 $11,200 $5,600	Not covered

Below are more details about the Basic Plan coverage, effective May 1, 2023. Also, the Schedule of Benefits summarizes the Basic Plan including medical, prescription, dental and vision.

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Ambulance Transportation		
Ground:		
• Copay Per Trip	$150	$150
• Coinsurance	0% (Deductible Waived)	0% (Deductible Waived)
Air:		
• Copay Per Trip	$1,000	$1,000
• Coinsurance	0% (Deductible Waived)	0% (Deductible Waived)
Breast Pumps		
• Maximum Benefit Per Birth	Provides for rental, and if not available, purchase of 1 Breast Pump, subject to cost-effective UMR review process	Only covered in the event that in-network not available.
• Coinsurance	0%	
• Paid By Plan	100% (Deductible Waived)	
Cardiac Pulmonary Rehabilitation		
• Maximum Days Per Calendar Year	60 Days	
• Coinsurance after Deductible met	30%	Not Covered
Cardiac Rehabilitation Phase 1 & 2:		
• Maximum Days Per Calendar Year	60 Days	
• Coinsurance after Deductible met	30%	Not Covered
Chiropractic Services:		
• Copay Per Visit	$10	Not Applicable
• Maximum Visits Per Calendar Year	40 Visits	
• Coinsurance after Copay	0% (Deductible Waived)	Not Covered
Visit maximums are applied based on provider designation and procedure code. If a provider bills for a manipulation and a therapy on the same claim, only one visit will be applied to the manipulation maximum based on the provider's designation.		
Cognitive Rehabilitation:		
• Maximum Days Per Calendar Year	60 Days	
• Coinsurance after Deductible met	30%	Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Contraceptive Methods and Contraceptive Counseling Approved by the FDA **For Men:** • Coinsurance after Deductible met **For Women:** • Coinsurance	 20% 0% (Deductible Waived)	 Not Covered
Counseling Services **Nutritional:** • Maximum Visits Per Calendar Year • Coinsurance after Deductible met **Note: Mental Health and Substance Abuse conditions are excluded from the maximum.**	 3 Visits 30%	 0 Visits Not Covered
Durable Medical Equipment • Coinsurance after Deductible met	 30%	 Not Covered
Emergency Services / Treatment **Urgent Care:** • Copay Per Visit • Coinsurance after Copay/Deductible met **Walk-In Retail Health Clinics:** • Copay Per Visit • Coinsurance after Copay/Deductible met **Emergency Room Only:** **(including Physician and Facility charges)** • Copay Per Visit including any continuous Observation (but less than 72 hours) that is part of the ER Visit and prior to any admission If Admitted Inpatient within 24 Hour(s) of initial ER Visit or after the Emergency Room visit and a period of continuous Observation that is less than 72 hours	 $75 0% (Deductible Waived) $25 0% (Deductible Waived) $250 Copay **30% Coinsurance** Copay waived; 30% after deductible	 Not Covered Not Covered $250 Copay 30% Coinsurance Copay waived; 30% after deductible
Extended Care Facility Benefits, Such as Skilled Nursing, Convalescent, Or Subacute Facility • Maximum Days Per Calendar Year • Coinsurance after Deductible met	 100 Days 30%	 Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Hearing Services **Exams, Tests:** • Coinsurance after Deductible met **Hearing Aids:** • Maximum Benefit Every 5 Years • Coinsurance after In-Network Deductible **Hearing Aid Exam:** • Maximum Exams Per Calendar Year • Coinsurance after In-Network Deductible **Note: Hearing Aid Benefit only available to Active Participants and Non-Medicare Retirees.**	 30% $2,000 per ear 30% 1 exam 30%	 Not Covered Not Covered Not Covered Not Covered Not covered
Home Health Care Benefits • Maximum Visits Per Calendar Year • Coinsurance after Deductible met	 100 Visits 30%	 0 Visits Not Covered
Hospice Care Benefits **Hospice Services:** • Coinsurance after Deductible met **Bereavement Counseling:** • Coinsurance after Deductible met	 30% 30%	 Not Covered Not Covered
Hospital System Owned Facility Services **Pre-Admission Testing:** • Coinsurance after Deductible met **Inpatient Services / Inpatient Physician Charges; Room and Board subject to the payment of Semi-Private room rate or negotiated room rate:** • Coinsurance after Deductible met **Surgeon Charges** • Coinsurance after Deductible met	 30% 30% 30%	 Not Covered Not Covered Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Outpatient Services / Outpatient Physician Charges: • Coinsurance after Deductible met	30%	Not Covered
Outpatient Diagnostic Lab • At Other Facilities Including Hospital, Coinsurance after Deductible met	30%	Not Covered
Outpatient Advanced Imaging Charges: • Coinsurance after Deductible met	30%	Not Covered
Outpatient X-Ray Charges: • Coinsurance after Deductible met	30%	Not Covered
Outpatient Surgery / Surgeon Charges: • Coinsurance after Deductible met • If surgery performed at physician office visit	30% 0% included as part of in-network office visit copay	Not Covered Not Covered
Orthopedic Health Support: • Contact OHS for support Monday – Friday, 7am – 6pm: 1.888.936.7246 | TTY 711	If you can join, you pay 10% coinsurance	Not Covered
Physician Clinic Visits in An Outpatient Hospital Setting - Facility Claim: • Coinsurance after Deductible met	30%	Not Covered
Physician Clinic Visits in An Outpatient Hospital Setting - Physician Claim: • Copay Per Visit - Primary Care Physician • Copay Per Visit – Specialist • Coinsurance after Deductible met	$25 $50 0% (Deductible Waived)	Not Covered Not Covered Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Lab, Radiology and Diagnostic Services **Lab Diagnostics:** • At LabCorp or Quest • At any other Lab Diagnostics **Radiology, X-rays, and Imaging:** • At Independently Owned, Freestanding Imaging Facilities (not Hospital or Physician Group Owned) • At any Hospital System Owned facility	 $0 Copay 30% $25 Copay (Deductible does not apply) 30%	 Not Covered Not Covered Not Covered Not Covered
Maternity: **Routine Prenatal Services:** • Coinsurance after Deductible met **Non-Routine Prenatal Services, Delivery, And Postnatal Care:** • Coinsurance after Deductible met	 0% (Deductible Waived) 30%	 Not Covered Not Covered
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits **Inpatient Services / Physician Charges:** • Coinsurance after Deductible met **Residential Treatment:** • Coinsurance after Deductible met **Outpatient Or Partial Hospitalization Services and Physician Charges:** • Coinsurance after Deductible met **Office Visit:** • Copay Per Visit • Coinsurance after Deductible met	 30% 30% 30% $25 0% (Deductible waived)	 Not Covered Not Covered Not Covered Not Covered
Orthotic Appliances: • Coinsurance after Deductible met **Foot Orthotics:** • Maximum Benefit Per Calendar Year • Coinsurance after Deductible met **Shoe Inserts-Custom Molded:** • Maximum Benefit Per Calendar Year • Coinsurance after Deductible met	30% 1 Orthotic Per Foot 30% $1,000 30%	Not Covered Not Covered Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Phenylketonuria (PKU) or Other Amino and Organic Acid Inherited Disease Formula and Food: **To Age 6** • Coinsurance after Deductible met	30%	Not Covered
Physician Office Services **Office Visits:** • Copay Per Visit - Primary Care Physician • Copay Per Visit - Specialist • Coinsurance after Deductible met **Office Surgery:** • Coinsurance after Deductible met • If surgery performed at physician office visit	 $25 $50 0% (Deductible Waived) 30% 0%	 Not Covered Not Covered Not Covered Not Covered Not Covered
Allergy Injections and Sublingual Drops If Billed Without An Office Visit: • Coinsurance after Deductible met	30%	Not Covered
Allergy Testing If Billed without an Office Visit: • Coinsurance after Deductible met	30%	Not Covered
Allergy Serum If Billed without an Office Visit: • Coinsurance after Deductible met	30%	Not Covered
Office Lab & X-Ray Imaging: • Coinsurance after Deductible met	0% included as part of in-network office visit copay	Not Covered
Office Advanced Imaging: • Coinsurance after Deductible met	30%	Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Preventive / Routine Care Benefits. See glossary of terms for definition. Benefits Include:		
Preventive / Routine Physical Exams at Appropriate Ages: • Maximum Exams Per Calendar Year • Coinsurance after Deductible met	1 Exam 0% (Deductible Waived)	Not Covered
Immunizations: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Note: Foreign Travel Immunizations will not be covered.		
Preventive / Routine Diagnostic Tests, Lab, and X- Rays at Appropriate Ages: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Preventive / Routine Mammograms and Breast Exams: From Age 35 To Age 39	1 Exam	Not Covered
• Maximum Exams Including 3D Mammograms for Preventive Screenings From Age 40 • Maximum Exams Per Calendar Year Including 3D Mammograms for Preventive Screenings • Coinsurance after Deductible met	1 Exam 0% (Deductible Waived	Not Covered
3D Mammograms for Preventive Screenings: Included In Preventive / Routine Mammograms and Breast Exams Maximum • Coinsurance after Deductible met	0% (Deductible Waived)	30% Not Covered
3D Mammograms for Diagnosis / Treatment of a Covered Medical Benefit: • Coinsurance after Deductible met	1 Exam 0% (Deductible Waived)	Not Covered
Preventive / Routine Pelvic Exams and Pap Tests: • Maximum Exams Per Calendar Year • Coinsurance after Deductible met		

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Preventive / Routine PSA Test and Prostate Exams: • Maximum Exams Per Calendar Year • Coinsurance after Deductible met	1 Exam 0% (Deductible Waived)	0 Exams Not Covered
Preventive / Routine Screenings / Services at Appropriate Ages and Gender: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed for Preventive Reasons: From Age 45 • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Preventive / Routine Hearing Exams: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Preventive / Routine Counseling for Alcohol or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
In Addition, The Following Preventive / Routine Services Are Covered for Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Coinsurance after Deductible met ***These Services May Also Apply to Men.**	0% (Deductible Waived)	Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Preventive / Routine Care Benefits For Children Include:		
Preventive / Routine Physical Exams: • Maximum Exams Per Calendar Year • Coinsurance after Deductible met	1 Exam 0% (Deductible Waived)	0 Exams Not Covered
Immunizations: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Note: Foreign Travel Immunizations will not be covered.		
Preventive / Routine Screenings At Appropriate Ages: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Preventive / Routine Autism Screening: From Age 18 Months To 24 Months • Coinsurance after Deductible met	0%	Not Covered
Preventive / Routine Diagnostic Tests, Lab, And X- Rays: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Preventive / Routine Hearing Exams: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Sterilizations: **For Men:** • Coinsurance after Deductible met	30%	Not Covered
For Women: • Coinsurance after Deductible met	0% (Deductible Waived)	Not Covered
Teladoc Services: **General Medicine:** • Paid By Plan	0% (Deductible Waived)	
Behavioral Health: • Paid By Plan	0% (Deductible Waived)	
Telehealth: • Copay Per Visit - Primary Care Physician • Copay Per Visit - Specialist • Coinsurance after Deductible met	$25 $50 0% (Deductible Waived)	Not Covered Not Covered Not Covered

BASIC MEDICAL PLAN	IN-NETWORK	OUT-OF- NETWORK
Temporomandibular Joint Disorder Benefits: • Coinsurance after Deductible met	30%	Not Covered
Therapy Services: • Copay Per Visit • Maximum Visits Per Calendar Year • Coinsurance after Deductible met **Note: Mental Health and Substance Abuse Conditions Are Excluded from the Maximum.**	$25 60 Visits 0% (Deductible Waived)	Not Applicable Not Covered
Vision Care Benefits: **Eye Exam part of Preventive Medical Office Visit:** To Age 21 • Maximum Exams Per Calendar Year • Paid By Plan **Vision Therapy:** • Coinsurance after Deductible met **Orthoptics:** • Coinsurance after Deductible met	 1 Exam 0% (Deductible Waived) 30% 30%	 Not Covered Not Covered Not Covered
All Other Covered Expenses: • Coinsurance after Deductible met	30%	Not Covered

TRANSPLANT SCHEDULE OF BENEFITS **The program for Transplant Services at Designated Transplant Facilities is: Optum Basic Medical Plan**	
Transplant Services: Designated Transplant Facility **Transplant Services:** • Coinsurance after Deductible met **Travel And Housing:** • Maximum Benefit Per Transplant • Minimum Benefit Per Day • Paid By Plan Travel And Housing at Designated Transplant Facility at Contract Effective Date/Pre-Transplant Evaluation and Up To One Year from Date of Transplant. ***Note: Lodging amounts exceeding the limit are the covered person's responsibility. Air travel is limited to the transplant covered person, plus one other person or for both parents if for child transplant covered participant.***	 30% $10,000 $50 Up To $100 For Two People, Including the Transplant Recipient 100% (Deductible Waived)

D. 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 unless the claims are covered by the No Surprises Act as explained in Section III(F).

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

1. **General Medical Networks**

   The Open Access Plus (OAP) Network, offered through UMR, 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).

2. **Carpenters Wellness Center**

   Located at 1403 Hampton Ave in St. Louis, MO, Carpenters Wellness Center is available to all covered Participants 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: laborfunds.org/wellnesscenterstl. The Wellness Center section of SPD includes a schedule of benefits available and copays applicable at the Center.

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

   b) Participants and Dependents covered under the United Healthcare Advantage Plan are eligible for pharmacy and purchase of materials at the vision center as well as dental care if optional dental coverage is elected.

3. **Transplant and Related Therapies Networks**

   The Plan's Transplant Network is a designated group of Providers within the UMR Optum TRS 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 certified CAR-T facility with a UMR approved stem cell transplant program.

4. **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 Benefit Office and on the Plan's website, laborfunds.org.

E. 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 Participant 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 Amount**

   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 and supplies not covered by Medicare, the reasonable and customary amount will be determined pursuant to a method approved 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 Participant and the Participant's Dependents, satisfies the Individual Deductible for the Participant and all of the Participant'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 the 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 Participant and the Participant's Dependents equals the Family Out-of- Pocket Maximum, the Individual Out-of-Pocket Maximum is satisfied for the Participant and all of the Participant'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 F 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 the covered services and supplies listed and designated as Preventive services and supplies in Subsection F.2 below, the benefit payable by the Plan is the Allowable Amount.

F. 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 F.1 and F.2 as covered; and
- Medically Necessary, unless otherwise stated in these Subsections F.1 and F.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 F.3 below.

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

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

   Inclusion of a service or supply in Non-Preventive Covered Services section 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 Preventive Covered Services are eligible for coverage regardless of Medical Necessity unless otherwise stated. Except as noted, benefits for Preventive services and supplies listed in Preventive Covered Services, 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 Preventive Covered Services 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 Preventive Covered Services, alone, does not guarantee benefits are payable.

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

   - Recommendations of the United States Preventive Services Task Force with a 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. Preventive Covered Services 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 the Excluded Services.

G. 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 Non-Preventive Covered Services and Preventive Covered Services. This list is subject to additions and changes.

(a) Abortion

(b) Non-Emergent Ambulance service by air and water, or transfers between facilities

(c) Breast pumps, Hospital grade

(d) Chemotherapy and Radiation Therapy

(e) Clinical Trials

(f) Dental Services (when covered under Medical Benefit)

(g) Dialysis

(h) Durable Medical Equipment for rentals over $500; purchases over $750 ($1,000 for prosthetics.)

(i) Genetic Testing and Counseling

(j) Home Health Care Services

(k) Hyperbaric treatment

(l) Inpatient Hospital Care, except maternity admission to a Hospital not exceeding 48 hours following a vaginal delivery or 96 hours following a Cesarean section

(m) Inpatient, Residential, Intensive Outpatient and Partial Hospitalization Mental and Nervous Disorders and Substance Abuse

(n) Outpatient surgeries not performed in a physician's office including cosmetic, plastic and related reconstructive surgeries Pain Management Injections

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

(p) CT scans, MRIs, MRAs, PET scans, nuclear cardiology

(q) Sclerotherapy

(r) Sleep Studies

(s) Skilled Nursing Facilities

(t) TMJ treatment – surgical or non-surgical

(u) 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 of 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 UMR Optum TRS 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.

H. MEDICAL CARE MANAGEMENT

The Plan maintains programs designed to provide education, support and coordination services to Participants 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.

3. **Orthopedic Health Solutions**

   Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond for joint-related conditions. This program offers:

   (a) Early intervention and appropriate care.
   (b) Coaching to support behavior change.
   (c) Shared decision-making.
   (d) Pre- and post-surgical counseling.
   (e) Support in choosing treatment options.
   (f) Education on back-related information and self-care strategies.
   (g) Long-term support.
   (h) Access to Designated Providers.

   Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the customer service number on the back of your ID card and ask for an Orthopedic Health Support nurse or you can call the Orthopedic Nurse Team at 888-936- 7246.

I. PROTECTIONS FROM SURPRISE MEDICAL BILLS

Under a federal law called the No Surprises Act, you have protections against surprise medical bills from certain kinds of items and services provided by Out-of-Network Providers and facilities. The Plan will cover Emergency Services provided at an Out-of-Network facility or by an Out-of-Network Provider in the same manner as In-Network Emergency Services. Air Ambulance (but NOT ground ambulance) services provided by an Out-of-Network Provider will also be covered in the same manner as In-Network Air Ambulance services. This means:

(a) The Plan will not impose cost-sharing requirements on Out-of-Network Emergency Services or Out-of-Network Air Ambulance services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or at an In-Network emergency facility. Your cost-sharing will be based on the Recognized Amount payable for these services.
(b) Any cost-sharing payments you make with respect to Out-of-Network Emergency Services and Air Ambulance services will count toward your In-Network deductible and Out-of-Pocket maximum in the same manner as payments made to In-Network Providers.
(c) The Plan will not impose prior authorization requirements for Emergency Services or Air Ambulance services and will not impose more restrictive administrative requirements on Out-of-Network Emergency Services or Air Ambulance services than those imposed on In-Network Emergency Services or Air Ambulance services.

If you receive non-emergency items or services that are otherwise covered by the Plan from an Out-of-Network Provider during a visit at an In-Network facility, those non-emergency items or services will be covered by the Plan as follows:

(d) The non-emergency items or services received from an Out-of-Network Provider during a visit at an In-Network facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network Provider.
(e) In general, you cannot be balance billed for these non-emergency items or services. Your cost-sharing will be based upon the Recognized Amount payable for these services.
(f) Any cost-sharing payments you make with respect to covered non-emergency items and services will count toward your In-Network deductible and Out-of-Pocket Maximum in the same manner as those received from an In-Network Provider.

In certain circumstances, you can be billed by an Out-of-Network Provider during a visit to an In-Network facility. This can occur if you are notified by the Out-of-Network Provider that they do not participate with the Plan and proper notice and consent procedures are followed. The Provider must give you a notice stating certain information required by federal law, including that the Provider is an Out-of-Network Provider with respect to the Plan, the estimated charges for your treatment, and any advance limitations that the Plan may put on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred

to one of the In-Network Providers listed.

If you give informed consent to waive your balance billing protected under the No Surprises Act, then the Plan will treat these services as Out-of-Network, and the Provider can bill you for the balance directly. However, you cannot waive balance billing protections for:

(g) Ancillary Services at an In-Network facility, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services, and items and services provided by an Out-of-Network Provider if there is no In-Network provider who can furnish such item or service at such facility; or
(h) Services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

The amount of your cost-sharing for such services will be based on the Recognized Amount. The Recognized Amount is generally the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount. The Qualifying Payment Amount generally means the median amount the Plan has contractually agreed to pay In-Network Providers, Facilities, or Providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

J. CONTINUITY OF CARE

Under the No Surprises Act, if you are a Continuing Care Patient, and the contract between the Plan and your In-Network Provider or facility terminates, or your benefits are terminated because of a change in terms of the Providers' and/or facilities' participation with the Plan:

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

You are a Continuing Care Patient with respect to a Provider or facility if you are:

(c) undergoing a course of treatment for a serious and complex condition from the Provider or facility;
(d) undergoing a course of institutional or inpatient care from the Provider or facility;
(e) scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such surgery;
(f) pregnant and undergoing a treatment for the pregnancy from the Provider or facility; or
(g) determined to be terminally ill and is receiving treatment for such Illness from such Provider or facility.

K. 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 sublingual drops, 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	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, including, transportation that is primarily for repatriation (e.g., to return the patient to the United States)

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	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.	
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. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.	**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.
Autism Spectrum Disorders (ASD) Treatment	Diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy	**Limitations:** subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services **Exclusions:** Services or treatment identified elsewhere in the Plan as non- covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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 Pumps	Include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth	
Breast Reconstruction	Following a Medically Necessary mastectomy, breast reconstructive surgery and prosthesis are covered regardless of 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.
Breastfeeding Support, Supplies, and Counseling	In conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period.	
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	Cardiac Rehabilitation programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions. Covered services include: • Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.	**Limitations:** 60 visits per calendar year.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	• Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.	
Cataract or Aphakia Surgery	Including surgically implanted conventional intraocular cataract lenses following such a procedure. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.	**Exclusions:** Multifocal intraocular lenses are not allowable.
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	If performed by a Qualified chiropractor. The Plan also covers services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions.	**Limitations:** Benefits are limited to 40 visits per calendar year per patient with no per visit or annual dollar limits. **Exclusions:** Services performed for Maintenance
Circumcision	Including related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.	
Cleft Palate and Cleft Lip	Benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.	
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	Prior Authorization required. **Exclusions:** Patient care for any clinical trial that does not meet the stated criteria; any

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	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.	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.
Contraceptives and Counseling	All Food and Drug Administration- approved contraceptive methods, sterilization procedures, and patient education and counseling. The following contraceptives will be processed under the medical Plan: • Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose. • Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose. • Vasectomy.	**Exclusions:** Reversal of vasectomy.
Corneal Transplants	Transplants are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.	
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	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

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	under the Plan's criteria for breast reconstruction following a covered mastectomy. Also see Breast Reconstruction.	restore or improve impaired physical function. Listed service or supply if Prior Authorization was not obtained.
Dental Services	Dental Services include: • The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), or for treatment of cleft palate, excluding implants. Treatment must be completed as soon as medically appropriate of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period • Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if necessary due to the patient's age of 4 years or under, due to intellectual disabilities, or because an individual has medical conditions that may cause undue medical risk. Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.	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 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, diabetic shoes, 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.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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; • augmentation communication devices and related instruction and therapy; • purchase of elastic garments; • purchase of oxygen and equipment for the administration of oxygen; • mechanical equipment necessary for the treatment of chronic or Acute respiratory failure (ventilators and respirators); • sleep apnea machines 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.

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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.
Emergency Services Provided in a Foreign Country	Services and supplies furnished or required to screen and stabilize an Emergency medical condition, when provided on an inpatient or outpatient basis at either a Hospital or Physician services in a provider's office	**Exclusions:** No benefits are payable for non-Emergency services received in an Emergency Room or an Urgent Care Facility.
Eye Refractions	Covered if related to a covered medical condition	
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.
Gender conforming or Gender Reassignment Services	Covered in the case of a child born with ambiguous or atypical genitalia	

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Genetic Testing and Counseling	Covered based on Medical Necessity. Genetic testing MUST meet the following requirements: The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. Genetic testing must also meet at least one of the following: • The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes). • Conventional diagnostic procedures are inconclusive. • The patient has risk factors or a particular family history that indicates a genetic cause. • The patient meets defined criteria that place them at high genetic risk for the condition.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Hearing Services	Hearing examination, maximum once per year, tests, services and supplies to diagnose and treat a medical condition. Hearing Aid device, $$2,000 per ear every five years.	**Limitations:** Hearing exams are available to dependents as part of routine and diagnostic benefits. Hearing Aid devices are available only to Participants in the Active classification and non-Medicare Retired Participants. No coverage for dependents (spouse and/or children).
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.	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.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	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.	
Hospice	Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and may include: • **Assessment**, which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs. • **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part- time Home Health Care services. • **Outpatient Care**, which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician. • **Bereavement Counseling** services when part of a hospice program that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.	

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Hyperbaric Oxygen Therapy (HBOT)	Hyperbaric Oxygen Therapy is covered.	Prior Authorization required. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Implants and Related Health Services	Implant devices and related implantation services including pacemakers, joint replacements, AEDs, implantable TENS units, spinal braces, penile implants), and implants for the delivery of prescription medication. Repair and maintenance of prior implants is covered when Medically Necessary subject to Prior Authorization. See also Preventive implants for contraception under Preventive services.	Prior Authorization required for implants and repair 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 related to the implant.
Impotence	Diagnosis and treatment of impotence is covered.	**Prior Authorization required to the extent any surgery is needed.**
Infertility	Only diagnostic studies up to the point of an infertility diagnosis are covered.	Prior Authorization required. **Exclusions:** Treatment of infertility. Genetic testing. 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, during an inpatient stay, outpatient facility care, physician visit (s) or other approved setting.	**Exclusions:** Self-Injectable medications are excluded from the Medical Benefit and may be available under the Prescription Drug Benefit.

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Inpatient Hospital Care	Semi-private (or Private if Semi-Private not offered) 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. Observations in a Hospital room will be considered inpatient hospital care if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an inpatient or can be discharged from the hospital setting.	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.
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.

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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.	**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	Medical services performed as part of a Physician's Office Visit are generally covered as part of the copay for the Office Visit. This includes surgeries and diagnostic tests conducted as part of the Office Visit.	
Member Assistance Program (MAP)	Regardless of 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.

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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. **Inpatient Services** means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual- diagnosis facility for the treatment of Mental Health Disorders.	Prior Authorization required for all facility services.
Morbid Obesity Treatment	Includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition: • Bariatric surgery, including, but not limited to Gastric or intestinal bypasses , stomach stapling, lap band, gastric sleeve procedure; charges for diagnostic services and nutritional counseling by registered dieticians or other Qualified Providers.	Prior Authorization required. Exclusions: The plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD.
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 to another facility when the current facility is appropriately staffed and equipped to treat the newborn's condition. Listed service or supply if Prior Authorization was not obtained.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Nutritional Supplements, Enteral and Parenteral Feedings, Vitamins and Electrolytes	Nutritional Supplements, Enteral and Parenteral Feedings, Vitamins, and Electrolytes that are prescribed by a Physician and administered through a tube or taken orally are covered, provided they meet the following criteria: They are the sole or partial source of nutrition, as determined medically necessary by a Physician for a specified period. They are part of a chemotherapy regimen. This coverage also includes supplies related to enteral feedings, such as feeding tubes, pumps, and other necessary materials, as long as the feedings are prescribed by a Physician and meet the above criteria.	Prior authorization required for enteral and parenteral feeding. **Exclusions:** Nutritional support taken solely on an oral basis (unless medically necessary as defined in the UnitedHealthcare June 1, 2023, Commercial Medical Policy titled "Enteral Nutrition (Oral and Tube Feeding)") and any over-the-counter care.
Office Visits	Services and supplies are covered as part of the copay if appropriately provided during an office visit by 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. • Diagnostic tests (for example X- ray and lab) and surgeries performed during the office visit.	Allergy testing and injections subject to deductible and coinsurance if no office visit. Advanced imaging subject to deductible and coinsurance or $25 copay for free-standing facilities. **Exclusions:** Self-injectable medications and the cost of specialty 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. 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. 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.
Outpatient Hospital Services	Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.	

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 that are recommended by a Physician as a result of infection. The following charges for foot care will also be covered: • Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed. • Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease. • Physician office visit for diagnosis of bunions. • The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed	**Exclusions:** Palliative Footcare Other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot. Over the counter inserts are excluded. Trimming of nails, corns, or calluses when there is not a metabolic disease (routine foot care)

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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 Preventive Covered Services.	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 Preventive Covered Services	
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 Covered Services, 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.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Reconstructive Surgery	See Breast Reconstruction and Cosmetic, Plastic and Reconstructive Surgery.	
Rehabilitation Services and Supplies Visits	Therapy prescribed by attending Physician, and provided in an outpatient setting by a Qualified Provider within the scope of their respective licenses, includes: • **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable. • **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable. • **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable. • **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable. • **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, Autism Spectrum Disorder and/or developmental delays. The Plan allows coverage for medical charges, and occupational and/or physical therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome, and cerebral palsy when performed by a Qualified Provider. The Plan allows coverage for the treatment of disorders such as speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, or a Congenital Anomaly.	**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 if that can be maintained without the therapy, as opposed to improving functional status. Educational or vocational therapy designed to retrain patient for employment. 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.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular Accident. See also Home Health Care Services for therapy administered in home or in a custodial setting.	
Second Surgical Opinion	If given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.	
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 and Sleep Disorders	Sleep studies to diagnose obstructive sleep apnea are covered and treatment for sleep disorders if medically necessary.	Prior Authorization require for outpatient or facility basis. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.
Sterilization	Vasectomy is a covered procedure Tubal ligation is covered as a Preventive benefit; see Preventive Covered Services.	**Exclusions:** Reversal of sterilization is not covered.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Surgeon Services	If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.	Subject to prior authorization.
Telehealth	Consultations made by a Physician via virtual media subject to applicable copay.	
Telemedicine	Covered with Teladoc at no copay. See Teladoc section for more information.	
Temporomandibular Joint Disorder (TMJ) Services	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.	Prior authorization for any surgical procedure. EXCLUSIONS: Orthodontic treatment of TMJ, and orthodontic appliances for such treatment.

NON- PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Transplant Travel Benefits *Contact UMR for more detailed information regarding the Optum TRS Transplant Travel Program.	Travel Benefits are available only for an organ transplant Participant 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 Participant 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 Participant 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 Participant's responsibility. Air travel is limited to the transplant Participant, plus one other person or for both parents if for child transplant Participant.
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 certified CAR-T facility with a UMR 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 UMR Optum TRS 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.
Walk-In Retail Health Clinics	Charges associated with medical services provided at Walk-In Retail Health Clinics.	
Wellness Center Services	Services at any Wellness Center sponsored by the Fund.	

L. PREVENTIVE SERVICES

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 Premium and Basic 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. Anxiety Screening 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 45 years of age. Depression Screening. Type 2 Diabetes Screening - Screening for adults with high blood pressure. Nutritional (diet) and physical activity counseling – for adults at higher risk for chronic disease. Exercise interventions to prevent falls in adults 65 years or older who are at increased risk for falls. Hepatitis C Screening HIV preexposure prophylaxis (PreP) – antiretroviral therapy for adults at increased risk. 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	**Limitations:** A listed service or supply is covered once each calendar year, unless otherwise stated. Nutritional counseling limited to 3 per year, except if related to Mental Health/Substance abuse conditions.

PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	• 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 Latent TB Infection Screening – for adults at increased risk Lung cancer screening for certain adults age 50- 80 with history of risk factors. Obesity Screening and counseling. Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk. Skin cancer prevention counseling Statin for adults over age 40 with one or more cardiovascular disease risk factors and an estimated 10-year risk of a cardiovascular event of 10% or greater. 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. Unhealthy Drug Use Screening – asking questions about unhealthy drug use.	
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. Aspirin for those at high risk of preeclampsia during pregnancy Bacteriuria - urinary tract or other infection screening for pregnant women. Behavioral counseling on healthy weight and weight gain for pregnant women BRCA-related cancers – risk assessment, genetic counseling, and genetic testing Breast Cancer Mammography screenings – including 3D Mammograms – one baseline	**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
	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 women ages 21 – 65. 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. Counseling for pregnant and postpartum persons who are at increased risk of perinatal depression Domestic and interpersonal violence screening and counseling. Folate supplements for women who may become pregnant. Gestational diabetes screening - for women 24 weeks pregnant or later and those at high risk of developing gestational diabetes. 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.	

PREVENTIVE SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	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. Anxiety screening for children and 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. Hearing screening for all newborns. Height, Weight and Body Mass Index measurements.	**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
	Hematocrit or Hemoglobin screening. Hemoglobinopathies or sickle cell screening for newborns. HIV preexposure prophylaxis (PreP) – antiretroviral therapy for adolescents at increased risk 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. Skin cancer prevention counseling Syphilis screening – for adolescents at increased risk Tuberculin testing for children at higher risk of tuberculosis. Vision screening.	

M. MEDICAL EXCLUSIONS

1. Any service or supply not Medically Necessary for the treatment of a Illness 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 Covered Preventive Services section above as being covered regardless of 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 Illness, or any Injury or Illness 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 Illness or Injury or other condition that is court-ordered or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while- intoxicated conviction or other classes ordered by the court.
6. Acupuncture services and associated expenses of any kind, including, but not limited to, treatment of painful conditions or for anesthesia purposes.
7. 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.
8. Alternative Therapies – Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies, hypnosis, homeopathic therapies and any related diagnostic testing.
9. Assistance with Activities of Daily Living
10. Autopsy – Services and associated expenses related to the performance of autopsies.
11. Before Enrollment and After Termination – Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.
12. Biofeedback services
13. Blood Donor expenses
14. Blood Pressure Cuffs/Monitors unless prescribed by an authorized provider.
15. Braces or supports needed solely for athletic participation or employment.
16. Cardiac Rehabilitation – Beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.
17. Charges over 12 months old from the incurred date when submitted for consideration to the Plan.
18. 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 as a Covered Service under Cosmetic, Plastic and Related Reconstructive Surgeries.

19. Counseling – Services and treatment related to financial counseling, family planning counseling, religious counseling, marital and relationship counseling, vocational or employment counseling and sex therapy, except as expressly listed in Covered Services or as provided in the Member Assistance Plan.
20. 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.
21. Duplicate Services and Charges or Inappropriate Billing – including preparation of medical reports and itemized bills.
22. Educational Services – Educational services for remedial education.
23. Equipment or services for use in altering air quality or temperature.
24. 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 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.
25. Electrical continence aids; anal or urethral
26. Enteral Feeding Food Supplement – The cost of outpatient enteral tube feedings or formula and supplies, except as expressly listed in Covered Services. Over the counter supplements and supplies are excluded.
27. Examinations conducted for purposes of medical research or to obtain or maintain a license of any type or for employment or litigation purposes, including physical, psychiatric, or psychological examinations or testing, vaccinations, immunizations, or treatments.
28. Excess Charges – Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act
29. Exercise equipment
30. Experimental, Investigational, or Unproven – Services supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD
31. Extended Care – Any Extended Care Facility services that exceed the appropriate level of skill required for treatment as determined by the Plan.
32. Eyeglasses and Contact Lenses – provision or fitting of eyeglasses or contact lenses, except for the first pair of prescription eyeglasses after cataract surgery as prescribed by a physician. See Vision benefits.
33. Orthoptic therapy and eye exercises, radial keratotomy, Lasik, and other refractive eye surgery, except as listed in covered Vision Therapy services. See also Vision benefits.

34. Fitness Programs – General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.
35. Food or Food Supplements
36. Foot Care (Podiatry) – Routine foot care such as palliative footcare, trimming of nails, other hygienic and preventive maintenance care or debridement such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered persons; and any services performed in the absence of localized illness, injury or symptoms involving the foot.
37. Gender conforming or gender reassignment services except in the case of a child born with ambiguous or atypical genitalia.
38. Gene therapy products and their administration.
39. Growth hormone, except as expressly listed in Non-Preventive Covered Services.
40. Hair analysis, hair styling, wigs, and hair transplants, whether or not ordered by a Physician.
41. Home Services to help meet personal, family, or domestic needs.
42. Health and athletic club membership – Any expenses of enrollment and membership in a health, athletic or similar club.
43. Hearing therapy
44. Home Modifications – Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.
45. 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.
46. Home obstetrical delivery
47. Hypnotherapy
48. Hypnosis
49. Infant Formula – formula not administered through a tube as the sole source of nutrition for the Covered Person.
50. Illegal Activity - Injury or Illness resulting from participation in or, as a consequence of having participated in, any criminal or Illegal Activity or enterprise.
51. Immunizations for travel or employment, except as expressly listed in Covered services.
52. 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.
53. Premium Intraocular Lenses – Lenses other than mono-focal intraocular cataract lenses.
54. Lamaze Classes – including other birthing classes.

55. Learning Disability Services that are Non-Medical – Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
56. Liposuction
57. Maintenance therapy
58. Massage therapy unless provided at a Wellness Center sponsored by the Plan
59. Maximum Benefit – Charges in excess of any maximum benefit allowed as permitted the Plan.
60. 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 other applicable federal law; 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.
61. Missed appointment charges or charges for time spent traveling.
62. Naturopathic or holistic services
63. Nocturnal Enuresis Alarm
64. Non-Custom-Molded Shoe Inserts
65. Non-Professional Care – Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of their license.
66. Non-emergency care when traveling outside the United States.
67. Orthognathic, Prognathic, and Maxillofacial Surgery, if related to cosmetic and/or is not medically necessary.
68. Over-the-counter supplies and medications unless expressly listed under Covered Services and Supplies.
69. Panniculectomy – unless determined by the Plan to be Medically Necessary
70. Personal Comfort – services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones, and guest trays.
71. Pharmacy Consultations – Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.
72. Prescription drugs prescribed by a provider for the patient to receive at a retail or mail order pharmacy, except as provide through the Prescription Drug Benefit.
73. Private duty nursing services
74. Respite Care
75. Return to Work / School – Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.
76. Room and Board Fees, after surgery is performed, at locations other than at a Hospital or Surgical Center.

77. Self-Administered Services or procedures, including self-administered or self-infused medications, which can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.
78. Self-Injectable medications, except as covered in the Prescription Drug Benefit.
79. Services provided by a School
80. Services at No Charge or Cost – Services for which the Covered Person would not be obligated to pay in the absence of this Plan, such as part of a study, grant or research program, free clinics, free government programs, court-ordered care, or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.
81. Sex Therapy
82. Standby Surgeon Charges
83. Taxes – Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.
84. Third-Party Liability - Services or supplies received to diagnose or treat any Injury or Illness 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.
85. Smoking cessation programs, except the Plan's approved program covered as a listed Preventive benefit.
86. Transportation for delivery of home health care.
87. Transsexual surgery and associated charges including, without limitation, gender reassignment and gender conforming services.
88. Travel – Travel costs, unless covered elsewhere in this document.
89. Vocational Services – Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.
90. War-Injury or Illness 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 Illness), whether in peacetime or wartime and whether intended or accidental.
91. 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.
92. Wrong Surgery – Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, or other similar situations.

N. ADDITIONAL MEDICAL DEFINITIONS

1. **"Abortion"** means the termination of Pregnancy before the fetus reaches the stage of viability
2. **"Acute"** refers to an Illness or Injury that is both severe and recent onset
3. **"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.
4. **"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
5. **"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.
6. **"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.
7. **"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 Illness or Injury.
    c. It is generally not useful to a person in the absence of a Illness 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 Illness.
8. **"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.

9. **"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.
10. **"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 Illness or bereavement.
11. **"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:
    b. general inpatient care and treatment of Illness or Injury through medical, diagnostic, and major surgical facilities on its premises, or
    c. specialized treatment for mental and nervous disorders.
    d. 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.
12. **"Infertility Services"** means those Health Services designed for the primary purpose of successfully fostering and achieving conception and Pregnancy.
13. **"Injectable"** medication is prescription medications injected by or under the direct supervision of a Physician.
14. **"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.
15. **"Managed Mental Health and Substance Abuse Network"** means the organization with whom the Plan has contracted to administer the Managed Mental Health Care program.
16. **"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.
17. **"Physical Therapy**" means the rehabilitation concerned with restoration of function and prevention of disability following Illness 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.
18. **"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.

19. **"Pregnancy"** means the state of being pregnant, childbirth, miscarriage, and any complications arising from any of these conditions.
20. **"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).
21. **"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.
22. **"Self-Injectable"** medication is medication that is injected by the patient or patient's caregiver.
23. **"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.
24. **"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.
25. **"Speech Therapy"** means the remediation or rehabilitation for speech and language impairments.

CARPENTERS
BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

SECTION IV
WELLNESS CENTER BENEFITS

SECTION IV - WELLNESS CENTER BENEFITS

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WELLNESS CENTER

A. BACKGROUND INFORMATION

Carpenters Wellness Center is available to all covered Participants and Dependents ages 2 and older covered under the Active Plan (Premium or Basic) or Non-Medicare Retiree Plan 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
- Audiology Services
- 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
- X-ray

For enrolled Medicare retirees in the Carpenters Medicare plan, the following Wellness Center services are available:

- Purchase of materials at the Vision Center
- Dental Care (if enrolled in Dental Medicare plan)
- Access to the Wellness Center Pharmacy
- Purchase of hearing aids

Updated services and hours of operation are listed on the Plan's website:
laborfunds.org/wellnesscenterstl

The Wellness Center section of this SPD includes a schedule of benefits available and copays applicable at the Center:

- Participants and Dependents covered under the UnitedHealthcare Medicare Advantage Plan are eligible for pharmacy and vision care services as well as dental care if optional dental coverage is elected.

Carpenters Wellness Center is located at:

- 1403 Hampton Ave in St. Louis, MO

The Wellness Center located at 1403 Hampton Avenue in St. Louis offers the following services:

- Medical
- Prescription
- Dental

- Audiology
- Vision

Each of these services are described below in terms of what is offered and if any copay is charged for the service.

B. CARPENTERS WELLNESS CENTER BENEFITS

The Wellness Center offers certain services that are also offered under the Medical plan but the services offered at the Wellness Center are available at generally no or lower costs to the Participant. The Wellness Center also offers certain services that are not otherwise covered under the Medical plan, such as Massage Therapy.

MEDICAL BENEFITS AT
CARPENTERS WELLNESS CENTER

CARPENTERS WELLNESS CENTER MEDICAL BENEFITS	YOU PAY
Annual Deductible Per Calendar Year: • Per Person • Per Family	 $0 $0
Plan Coinsurance Rate, **Unless Otherwise Stated in the Schedule Below** • Paid By Plan After Satisfaction of Deductible	100%

Below are more details about the medical coverage at the Wellness Center:

CARPENTERS WELLNESS CENTER BENEFITS	YOU PAY
Primary Care Services:	
• Paid by Participant	$0
Annual School and Sports Physicals:	
• Paid by Participant	$0
Acute Care & Sick Care Visits:	
• Paid by Participant	$0
Chiropractic Care:	
• Paid by Participant	$0
Holistic Pain Management:	
• Paid by Participant	$0
Lab Services:	
• Paid by Participant (Internal Order)	$0
• Paid by Participant (External Order – PCP Participant)	$0
• Paid by Participant (External Order – Non-PCP Participant)	$20 copay
Massage Therapy	
• Paid by Participant	$0
Mental Health and Substance Abuse Counseling:	
• Paid by Participant	$0
Patient Education:	
• Paid by Participant	$0
Physical Therapy:	
• Paid by Participant	$0
Wellness Training:	
• Paid by Participant	$0
X-Ray Imaging:	
• Paid by Participant (Internal Order)	$0
• Paid by Participant (External Order – PCP Participant)	$0
• Paid by Participant (External Order – Non-PCP Participant)	$20 copay
Durable Medical Equipment (DME)	
• Paid by Participant	$20 copay

Participants who are more than 10 minutes late (or miss) a scheduled appointment and who do not contact the Wellness Center at least 10 minutes prior to the start of the appointment will be charged a $20 "No Show" fee.

C. CARPENTERS PHARMACY CENTER

Carpenters **Pharmacy Center** allows patients to pick up prescriptions after seeing their care providers. The pharmacy makes it easy to transfer prescriptions from other providers, as well as pick up medication for covered dependents.

The majority of the prescriptions picked up at the Center are available at no cost to the Covered Individual.

CARPENTERS PHARMACY CENTER BENEFITS

CARPENTERS PHARMACY CENTER BENEFITS	YOU PAY
Retail Pharmacy: Formulary	
Generic Medication: • Paid by Participant	$0
Preferred Brand Medication: • Paid by Participant	$0
Non-Preferred Brand Medication: • Paid by Participant	$0
Specialty Medication: • Paid by Participant	$0
Retail Pharmacy: Non-Formulary	
Generic Medication: • Paid by Participant	Medication Cost
Preferred Brand Medication: • Paid by Participant	Medication Cost
Non-Preferred Brand Medication: • Paid by Participant	Medication Cost
Specialty Medication: • Paid by Participant	Medication Cost
Over the Counter Medications (as available): • Paid by Participant	Offered at Discounted Rates

D. CARPENTERS DENTAL CENTER

Carpenters Dental Center, operated by **Onsite Dental,** offers comprehensive dentistry, exams, x-rays, cleanings, and fillings. Other services offered include dentures and crowns, as well as extractions and root canals on a case-by-case basis.

Many standard dental services offered at the Center are available at no cost to the Covered Individual.

CARPENTERS DENTAL CENTER BENEFITS

CARPENTERS DENTAL CENTER BENEFITS	YOU PAY
Annual Deductible Per Calendar Year:	
• Preventive Services	$0
Annual Deductible Per Calendar Year:	
• All Other Services	$0
Preventive Services	
• Paid by Participant	$0
Basic Services:	
• Paid by Participant	$0
Major Services:	
• Paid by Participant:	
– Repair (Tooth or Crown)	$25
– Porcelain/Ceramic Fillings & Onlays	$100
– Crowns	$200
– Dentures - New	$250
– Denture - Rebase or Reline	$50
– Abutments	$300
Orthodontic Services*:	Limited services only
Maximum Benefits:	
• Annual Maximum (Excluding Orthodontia)	None
• Lifetime Maximum (Orthodontia Only)	Not Available

*Traditional orthodontic services are not offered at the Dental Center. However, certain orthodontic devices such as athlete mouthguards or Brux devices are available with the copay amount paid by the participant varying based on materials used and type of device. Please check with the Dental Center for more information.

The copays for services listed above are broad categories meant to provide an overview of expected Participant copays for the more common services that require a copay but are not an exhaustive list. Please refer to the latest Carpenters Dental Center fee schedule for a more detailed description of copays for all covered dental services.

Dental care is available to Participants and Dependents covered by Non-Active retiree coverage only if optional dental coverage is elected.

E. AUDIOLOGY BENEFITS AT WELLNESS CENTER

Carpenters Wellness Center offers audiology services, operated by Concierge Hearing. Services include hearing exams, hearing aids, and custom moldings.

AUDIOLOGY BENEFITS

CONCIERGE HEARING AUDIOLOGY BENEFITS CARPENTERS WELLNESS CENTER	YOU PAY
Hearing Exams: • Maximum Exams Per Year • Paid by Participant	 1 Exam $0
Hearing Aid Benefits: **Premium Receiver in the Canal Aids** • Frequency • Paid by Participant **Custom Earmold in the Canal Aids** • Frequency • Paid by Participant	 Every 5 Years $150 per Aid Every 5 Years $150 per Aid

Hearing Aid Devices are only available to Active Participants and Non-Medicare retirees. Participants who do not qualify for coverage of a hearing aid may purchase a hearing aid from the Audiology provider but are required to pay the Audiology provider directly with no subsidy provided by the Plan.

F. CARPENTERS VISION CENTER

Carpenters Vision Center is operated by VSP. Services include eye exams, lenses (both traditional and contacts), and frames.

CARPENTERS VISION CENTER BENEFITS

CARPENTERS VISION CENTER BENEFITS	YOU PAY
Eye Exams:	
• Maximum Exams Per Year	1 Exam
• Paid by Participant	$0
Frames	
• Frequency	Every 24 Months
• Paid by Plan	$150 ($170 for Brand) 20% of
• Paid by Participant	Balance after Plan Paid
Standard Lenses	
• Frequency	Each Calendar Year
• Paid by Participant	$0
Lens Enhancements	
• Frequency	Each Calendar Year
• Paid by Plan (Standard Progressive)	$50
• Paid by Plan (Premium Progressive)	$80-$90
• Paid by Plan (Custom Progressive)	$120-$160
• Paid by Participant	Balance after Plan Paid Amount
Contacts (If Medically Necessary In Lieu of Glasses)	
• Frequency	Each Calendar Year
• Paid by Participant	$0
Contacts (If Elective)	
• Frequency	Each Calendar Year
• Paid by Plan	$150
• Paid by Participant	Balance after Plan Paid Amount
Safety Frames	
• Frequency	Each 24 Months
• Paid by Participant	$25

CARPENTERS
BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

SECTION V
PRESCRIPTION DRUG BENEFITS

Section V – Prescription Drugs

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PRESCRIPTION DRUGS

A. LEVELS OF BENEFIT

The Plan's Prescription Drug Benefit provides benefits for Medically Necessary prescription drugs, and also for some Preventive medications. Both the Premium and Basic Plan have the same prescription drug coverage. This Section V contains terms and conditions applicable to prescription coverage.

The Prescription Benefit Schedule below does not apply to prescriptions obtained from the Carpenters Wellness Center(s). Please refer to the Wellness Center Section for prescriptions available at the Wellness Center.

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

PRESCRIPTION BENEFIT SCHEDULE	Minimum Copaygg	Plan Coinsurance	Maximum Copaygg
Retail Pharmacy (30-day supply)			
Generic Medication	$10	90%	$20
Preferred Drug Medication	$20	70%	$75
Non-Preferred Medication	$30	60%	$125
Diabetes and Insulin Supplies (*including short-term continuous glucose monitors*)	$10	90%	$50
Retail Pharmacy (31 to 90-day supply)			
Mail Order Pharmacy (90-day supply)			
Generic Medication	$20	90%	$40
Preferred Drug Medication	$40	70%	$150
Non-Preferred Medication	$60	60%	$250
Diabetes and Insulin Supplies	$20	90%	$100
Specialty Medications			
Preferred Drug Medication	$40	65%	$150
Non-Preferred Medication	$40	60%	$250
SaveonSP Program Specialty Drugs			
Specialty drugs identified on Carpenters Health Plan's SaveonSp Specialty Drug List: www.saveonsp.com/carpdc	$0	100% if Enrolled 70% Otherwise *Does not count toward out-of-pocket*	No max
Individual Annual Out-of-Pocket		$3,500	
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:

- Prescribed by a Physician; and
- Legally required to be prescribed, except medications available over the counter (OTC) without prescription that are expressly covered in the Plan; and
- FDA approved for the condition for which prescribed; and
- Medically Necessary; and
- 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 aged 45-79; Women aged 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 aged 6to 12 months at risk for iron deficiency anemia	Generic OTC & RX Products
Smoking Cessation	Men and Women aged 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 aged 0H 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 & 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 Medical benefits are also covered under this the Prescription Drug Benefit herein, under the terms and conditions set forth in covered medical services. Without cost-sharing, and regardless of whether Medically Necessary or prescribed or administered by a Physician.
www.express-scripts.com/2024drugs

The above is the formulary in effect at the writing of this section. The formulary will change from time to time and the most recent is located at this link.

C. SPECIAL COVERAGE LIMITATIONS

The Plan's coverage of certain drugs and drug classes is subject to additional conditions and limitations described below.

1. **First Line Treatment Programs**
   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. For a list of drugs subject to the First Line Treatment program, you may contact customer service for Express Scripts at 800-939-2134 or visit express-scripts.com and input your Express Scripts ID number to get the specifics for your plan.

2. **Drug Quantity Management Program**
   Drug quantity management (DQM) is a program that makes sure that patients are using medications at doses that have been proven effective. It provides the medication you need for good health and the health of your family, while making sure you receive it in the amount – or quantity – considered safe.

For example, your doctor might write a prescription for two 20mg pills once a day. If the medication is available as a 40mg pill, you would need just one a day. Asking your doctor to prescribe the 40mg strength can save you and your plan money.

Drugs that aren't easily measured, like nose sprays and inhalers, are frequently included in DQM. U.S. Food & Drug Administration (FDA) guidelines recommend the maximum quantities of these drugs that are proven safe and effective.

DQM also lets the pharmacist know if you ask for a refill when you should still have medication left from the last time you filled the prescription.

3. **Step Therapy Programs**

Step therapy is a program that lets you get the safe and effective treatment you and your family need. It helps your plan sponsor maintain affordable prescription drug coverage for everyone your plan covers. In step therapy, medications are grouped in categories based on treatment and cost.

First-line medications are the first step. First-line medications are generic and lower-cost brand-name medications approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe and effective, as well as affordable. Step therapy suggests that you should try these medications first because in most cases they provide the same health benefit as more expensive drugs, but at a lower cost.

Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who don't respond to first-line medications. Second-line drugs are the most expensive options.

Contact Express Scripts Customer Service at 800-939-2134 or visit express-scripts.com and input your Express Scripts ID number to confirm whether step therapy applies to your prescription.

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 the descriptions later in this section.

D. EXCLUDED DRUGS

The Plan does not provide any prescription drug benefits for any of the drugs listed in later in this section, 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 a select 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 (70%) 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 Benefit Office or on the

Plan website at laborfunds.org. 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.

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 III.G.3 related to Medical Benefits.

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 Participant and the Participant'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 Participant and all the Participant'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.

H. DRUG SPECIFIC LIMITATIONS

1. **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.

2. **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.

3. **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.

4. **Hepatitis C Drugs 2**
   Covered only with Prior Authorization and per FDA indications and per revised CAC position statement changing the Metavir score criteria.

5. **Pain Medications**
   Products containing acetaminophen are covered only for prescribed cumulative daily dosage of 4g 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.

6. **PCKS9 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.

7. **Statins**
   Only generic drugs are covered. After August 1, 2016, new statins or statin combinations products are not covered unless approved by the Trustees.

8. **Stomach gastric) acid reduction Proton Pump Inhibitors (PPIs)**
   Only generic prescription products that are non-combination omeprazole, pantoprazole or lansoprazole are covered.

Other specific drugs are subject to prior authorization and other limitations. Call the Benefit Office or ESI to determine if your prescription is subject to prior authorization. The list of specific drugs is updated by the Board of Trustees from time to time based on recommendations by the UBC Advisory Committee.

I. 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 otherwise expressly covered by the Plan.
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. Cosmetic medications such as but not limited to Rogaine, Renova, or Propecia.
9. Smoking cessation agents, such as gum, patches and nasal spray including but not limited to Zyban, Nicorette, Habitrol, Nicoderm, Nicotrol, and ProStep, unless provided through a smoking cessation program approved by the Plan.
10. Weight loss medications. GLP-1s are a new class of drugs that have different coverage indication based on FDA approvals; The first indication for GLP-1s relates to Diabetes. The plan currently covers these drugs with a prior authorization for Type II Diabetes. Examples of these drugs are Ozempic, Trulicity, and Mounjaro. The second indication for GLP-1s is for obesity and weight loss. The plan does not cover these drugs along with other obesity or weight loss drugs. Examples of other weight loss drugs excluded from coverage are Wegovy and Saxenda.
11. 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), except as covered through ACA.
12. Drugs used to enhance or improve fertility.
13. Anabolic steroids, including Anadrol, Oxandrin, and Winstrol.
14. Any drugs, services or devices that do not satisfy the General Conditions of Coverage set forth in this section.
15. Drugs not FDA approved for the conditions for which prescribed.
16. Medications recommended to be excluded by the Clinical Advisory Committee, as approved and adopted by the Board of Trustees. A complete list of excluded medications is available upon request by contacting the Benefit Office.

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SECTION VI
DENTAL BENEFITS

Section VI – Dental

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DENTAL

A. ELIGIBILITY

Below is a summary of eligibility for the dental benefits offered in this program:

- **Active Classification** - The Premium Plan's Dental Benefit is provided automatically, without additional contributions, to Participants in the Active Classification and their Dependents.
- **Non-Active Classification** - The Premium Plan's Dental Benefit is available as optional coverage, at an additional Premium determined periodically by the Trustees, to Participants and Dependents in the Non-Active Classification including Participants and their Dependents enrolled in the UHC Medicare Advantage Program. The Premium 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.
- **For certain Apprentice eligibility classes**, the Basic Plan Dental is provided to Participants and Dependents. The Basic Plan Dental provides the same Preventive Services as the Premium plan but does not provide for other coverages offered under the Premium Plan. The Basic Plan offers access to the Delta Dental networks and discounts.

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 of 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.

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 (evaluations), twice in any benefit period • Problem focused exams, twice in any benefit period • Dental prophylaxis (cleaning, scaling, and polishing including periodontal maintenance visits), twice in any benefit period • Topical fluoride application for dependent children under age 19, twice in any benefit period
Emergency Palliative Treatment	• As needed (minor procedures to temporarily reduce or eliminate pain)
Radiographs	X-rays as required or in conjunction with the diagnosis of a specific condition. • Periapical x-rays as required • Bitewing x-rays twice per benefit period • Full-mouth x-rays once in any 36-month period
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.

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.
BASIC DENTAL SERVICES	
General Anesthesia	Covered in conjunction with covered surgical procedures
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	Periodontics: treatment for diseases of the gums and bone supporting the teeth. Periodontal surgery is covered only once in a 3-year period for the same site. Coverage for scaling and root planing are limited to once per 24 months
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 on all teeth, and relines and repairs to prosthetic appliances (bridgework and dentures).
MAJOR DENTAL SERVICES	
Prosthodontic Services	Services and appliances that replace missing natural teeth; includes fixed bridgework, partial dentures, and complete dentures.
Implants	Are a covered benefit; however, an alternate benefit allowance may be provided based on the cost of a removable partial denture or fixed bridge, when more than one tooth is missing on the same arch. Limited to once in 5 years per tooth. Bone grafts in conjunction with implants are not a covered benefit.
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.
Occlusal Guard	For bruxism only, limited to once in 5 years
Consultations	As required

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
ORTHODONTIC SERVICES	
Orthodontic Services	Services, treatment, and procedures required for the correction of malposed teeth. Applies to all eligible participants. Pick-up on orthodontic cases in progress.

C. BENEFIT STRUCTURE

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:

(a) the Delta Dental PPO Network and/or

(b) 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.

2. Deductibles, Coinsurance and Maximum Benefit Limits

Three levels of dental benefits are payable for Covered Services, as set forth in the following tables. The following charts summarize the benefit structure for the Premium Dental Plan and then for the Basic Dental Plan.

PREMIUM DENTAL PLAN			
	PPO NETWORK	**PREMIER NETWORK**	**OUT-OF-NETWORK**
Annual Deductible Per Calendar Year • Preventive Services • All Other Services	 $0 $50	 $50 $75	 $150 $150
Plan Coinsurance Rate, Unless Otherwise Stated Below: **Preventive Services** • Paid By Plan After Satisfaction of Deductible	 100%	 75%	 50%
Basic Services • Paid By Plan After Satisfaction of Deductible	80%	50%	25%
Major Services • Paid By Plan After Satisfaction of Deductible	50%	40%	25%
Orthodontic Services • Paid By Plan After Satisfaction of Deductible	50%	50%	50%
Maximum Benefit Limitations: • Annual Maximum Benefit excluding Orthodontia* • Lifetime Maximum Benefit, Orthodontia Only	 $1,500 plus Max Advantage** $1,500	 $1,500 plus Max Advantage** $1,500	 $1,500 plus Max Advantage** $1,500

*Per Covered Person, except for Dependent Child prior to 19th birthday.

**Refer to Section VI-D of the Plan Document regarding definition and detailed information regarding Max Advantage.

For certain apprentice eligibility classes, the Basic Dental Plan applies and includes the following provisions.

With respect to the Basic Dental Plan, the same covered services are included, however, the Participant pays for basic, major, and orthodontic services. After a 30-month waiting period, the participant generally transfers from the Basic Dental Plan to the Premium Dental Plan.

BASIC DENTAL PLAN			
	PPO NETWORK	**PREMIER NETWORK**	**OUT-OF-NETWORK**
Annual Deductible Per Calendar Year • Preventive Services	$0	$50	$150
Plan Coinsurance Rate, Unless Otherwise Stated Below:			
Preventive Services • Paid By Plan After Satisfaction of Deductible	100%	75%	50%
Basic Services • Paid By Plan After Satisfaction of Deductible	0%	0%	0%
Major Services • Paid By Plan After Satisfaction of Deductible	0%	0%	0%
Orthodontic Services • Paid By Plan After Satisfaction of Deductible	0%	0%	0%
Maximum Benefit Limitations:			
• Annual Maximum Benefit excluding Orthodontia*	$1,500 plus Max Advantage**	$1,500 plus Max Advantage**	$1,500 plus Max Advantage**
• Lifetime Maximum Benefit, Orthodontia Only	Not Applicable	Not Applicable	Not Applicable

*Per Covered Person, except for Dependent Child prior to 19th birthday.

**Refer to Section VI-D 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 Carpenters Wellness Centers. Please refer to the appropriate Wellness Center section.

D. ABOUT YOUR DENTAL DEDUCTIBLES AND MAXIMUMS

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.

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

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.

E. 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 Participant 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 G.

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 Participant 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 Participant 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.

F. 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 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 E2 and E3 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.

G. DENTAL 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 Participant 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. Non-orthodontic TMJ treatments may be covered as a medical benefit pursuant to Section III.
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 Illness 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 Illness 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 24-month 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).

H. DENTAL CLAIMS SUBMISSIONS

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.

I. 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 Participant of the Delta Dental Premier Network.
5. "Non-Network Dentist" means a Dentist or service Provider who is not a Participant 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 Participant 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 Participant of the Delta Dental PPO Network.

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SECTION VII

VISION BENEFITS

Section VII – Vision

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VISION

A. ELIGIBILITY

The primary purpose of the Premium Vision Benefit Plan is to assist eligible Participants and Dependents to obtain eyeglasses or contact lenses to improve visual acuity.

Below is a summary of eligibility for the vision benefits offered in this program:

- **Active Classification** - The Premium Vision Benefit Plan is provided automatically, without additional contributions, to Participants in the Active Classification and their Dependents.
- **Non-Active Classification** - The Premium Vision Benefit Plan is provided automatically, without additional contributions, to Participants in the Non-Active Classification not enrolled in the UHC Medicare Advantage plan.
- **For certain Apprentice eligibility classes**, the Basic Vision Plan is provided to Participants and Dependents. The Basic Vision Plan provides access to the VSP networks and discounts. The Basic Plan's Vision benefit provides access to VSP discounts and providers, but the participant pays for services at 100%.

The Vision Benefit is self-funded by the Plan. 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 of whether from In-Network or Non-Network Providers.

B. LEVELS OF BENEFIT

Network Provider

The 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.

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.

C. SCHEDULE OF VISION BENEFITS

Below is a summary of the Premium Vision Plan Benefits. Non-Network Providers require full payment at the time of service, as set forth in the following table:

PREMIUM VISION PLAN	VSP PROVIDER*	NON-VSP PROVIDER MAXIMUM BENEFIT*
Routine Eye Exam		
• Frequency	Every 12 Months	Every 12 Months
• Copay paid by Participant	$10	Greater of $10 or Balance After Plan Paid of $38
Prescription Glass Benefits		
Frames		
• Frequency	Every 24 Months	Every 24 Months
• Paid by Plan	$150	$45
• Paid by Participant	$25 plus 80% of Balance After Plan Paid	Greater of $25 or Balance After Plan Paid
Lenses		
• Frequency	Every 12 Months	Every 12 Months
• Paid by Plan (Single Vision Lens)	100%	$31
• Paid by Plan (Lined Bifocal Lens)	100%	$51
• Paid by Plan (Lined Trifocal Lens)	100%	$64
• Paid by Plan (Lenticular Lens)	100%	$80
Lens Enhancements		
• Frequency	Every 12 Months	Every 12 Months
• Paid by Plan (Standard Progressive)	$50	$0
• Paid by Plan (Premium Progressive)	$80-$90	$0
• Paid by Plan (Custom Progressive)	$120-$160	$0
Contact Lens Benefits		
Contacts (If Medically Necessary In Lieu of Glasses)		
• Frequency	Every 12 Months	Every 12 Months
• Paid by Plan	100%	$210
Contacts (If Elective)		
• Frequency	Every 12 Months	Every 12 Months
• Paid by Plan	$150	$105
• Lens Exam Included?	Yes	No

PREMIUM VISION PLAN, cont.		
	VSP Provider*	**Non-VSP Provider Maximum Benefit***
ProTec Safety Glasses		
Frames		
• Frequency	Every 24 Months	Not Covered
• Paid by Participant	$25	Not Covered
Lenses		
• Frequency	Every 24 Months	Not Covered
• Paid by Plan (Single Vision Lens)	100%	Not Covered
• Paid by Plan (Lined Bifocal Lens)	100%	Not Covered
• Paid by Plan (Lined Trifocal Lens)	100%	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.*

The Basic Plan's Vision Benefit provides access to VSP discounts and providers, but the participant pays for services at 100%. The Basic Plan includes the additional discounts listed under Subsection F.

D. COVERED VISION SERVICES AND SUPPLIES

The only services and supplies for which the Plan pays vision benefits are listed in the table set forth 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 E below; and
3. Are not excluded under the general exclusions set forth in Subsection G below.

E. ADDITIONAL CONDITIONS AND LIMITATIONS

1. Eye Examinations
2. Covered eye examinations include an evaluation of visual function and prescription of corrective lenses if needed.
3. For purposes of the VSP Provider maximum benefit, the Network scheduled amount is the amount the Provider has agreed to accept, as a Participant of the Network, for standard eye examinations as defined by VSP.
4. Eyeglass Lenses and Frames
5. 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.
6. 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 Participant 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 Participant 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.

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 Participant 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 2 and 3 above will apply.

Prior Authorization alone does not guarantee either coverage, or availability of benefits.

F. ADDITIONAL DISCOUNT

Each Participant 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, Participants 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.

G. 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 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 section above, and the General Exclusions section set forth 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 Participant of the Network; whereas Non-Network Providers are not limited in the amount they may charge.

H. 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 Illness 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.

I. 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 Participant 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 of 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.

J. 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.

CARPENTERS
BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

Section VIII
Short-Term Disability, Life Insurance and Safety Enhancement Benefits

Section VIII – Short-Term Disability, Life Insurance and Safety Enhancement Benefits

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SHORT-TERM DISABILITY, LIFE INSURANCE AND SAFETY ENHANCEMENT BENEFITS

A. SHORT-TERM DISABILITY BENEFITS

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

1. Eligibility for Short-Term Disability Benefits

Below is a summary of eligibility for the short-term disability benefits offered in this program:

a) Active Classification - The short-term disability benefit is provided automatically, without additional contributions, to Participants in the Active Classification, but excluding Non-Bargained Office Employees.

b) For Participants in the Basic Plan, the short-term disability benefit is not part of the benefits offered to them.

The Short-Term Disability Benefit is self-funded by the Plan. Therefore, all claims for short term disability benefits must be submitted to the Benefit Office.

If a covered Participant as above becomes temporarily Disabled because of a non-occupational accident or Illness that occurs while eligible for medical benefits in the Plan, such Participants is eligible to receive benefits under the terms and conditions stated below.

For this purpose, "Disabled" means that the Participant is prevented, due solely to the Illness or Injury, from engaging in gainful employment. In addition:

c) The Participant must be under the direct care and attendance of a Physician, who certifies the Participant is disabled within the foregoing definition and states an expected return to work date.

d) 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.

For Disability caused by an accident, the Participant must provide the Plan with complete details of time, place, and circumstances of the accident.

2. Benefits Payable

Benefits are payable under this section 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 (ii) for a Illness (without Hospital confinement or outpatient surgery, on the eighth day after the disability onset date certified by the Participant'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 Illness 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 Participant'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 Participant an annual Form W-2 form reporting the amount paid under this benefit for the calendar year.

3. Exclusions

No benefits are payable under this section:

a) For any day of disability which a Participant is eligible for, or receiving, compensation from the Participant's Employer, or Worker's Compensation benefits, even if occupational and non-occupational disabilities are unrelated.

b) For disabilities resulting from any Injury or Illness due to the act or omission of a third party unless the Participant has fully complied with the reimbursement and subrogation provisions of this Plan.

c) For periods that exceed accepted standards of disability, unless properly documented by the treating Physician.

d) For any day prior to or after the period when a Participant was under treatment, and was certified as disabled, by an attending Physician, even though the Illness may have been present.

e) For any day on which the Trustees determine a Participant was not disabled, though certified as such by a Physician.

f) For disability resulting from any Injury or Illness for which no medical benefits are payable.

g) For any Participant while covered under COBRA.

h) For any Participant or Dependent covered under Section I.A.3 as a Non-Bargained Office Employee.

B. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT 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, 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 Benefit Office. All claim forms needed to file for benefits under the Life insurance and AD&D policies can be obtained from the Benefit Office. The insurance carrier at the date of this restated Plan Document is Metropolitan Life Insurance Company (MetLife).

1. **Eligibility**

Below is a summary of eligibility for the life insurance and AD&D benefits offered in this program:

a) Active Classification - The life insurance benefit is provided automatically, without additional contributions, to Participants in the Active Classification and their Dependents, but excluding Non-Bargained Office Employees.

b) Non-Active Classification - The life insurance benefit is available to Participants and Dependents in the Non-Active Classification including Participants and their Dependents enrolled in the UHC Medicare Advantage Program. Certain re-instated non-active participants are not eligible for life insurance in this section. COBRA Participants are not eligible.

c) For Apprentice eligibility classes, the life insurance benefit is part of the benefits offered to them in the Basic Plan

d) Participants are eligible for AD&D benefits on the same basis as life insurance, provided that the Dependents are not eligible for AD&D benefits.

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 Participant	$8,000
Insurance on Life of eligible Dependent	$2,000
AD&D death benefit (Participants only)	$8,000

The Life insurance benefit is payable on account of death from any cause 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 Participant 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 Participant will be paid to the Participant's designated beneficiary.

A designated beneficiary is a person the Participant designates in writing on the Plan's form filed in the Benefit Office. If more than one beneficiary is named, the proceeds will be distributed equally to them unless the Participant has directed otherwise on the designation form. If any designated beneficiary predeceases the Participant, 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 Benefit Office at the time of death names a Participant'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 Participant. In the event there is no surviving designated beneficiary, or in the event there is no beneficiary designation on file in the Benefit Office, the death benefit for a Participant will be paid as follows:

a) To the Participant's Surviving Spouse.

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

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

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

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

A Participant 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 Participant signed the form, whether or not the Participant 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 Participant or, after the Participant's death, to the Participant'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 Participant, 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 (Participants Only)

If a Participant becomes Totally Disabled before age 60 while eligible for Life insurance benefits and if the Participant'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 Participant's death, provided the Participant:

a) Remains continuously Totally Disabled,

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

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

ii. 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 Participant'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 Illness or Injury the Participant cannot do the important duties of the Participant's job or any other job for which the Participant is fit by education, training, or experience.

5. Life Insurance Conversion Privilege (Participants and Dependents)

If a Participant'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 Participant or Dependent was entitled to convert, whether or not application had been made.

C. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

1. **Level of Benefits**

If a Participant sustains an accidental loss of limb or sight, the Participant 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:

   i. by an external or internal wound which was sustained in an accident; or

   ii. 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 Participant may obtain a complete copy of the AD&D insurance certificate by contacting the Benefit Office.

3. **Exclusions**

No benefits are payable under this section:

a) For any Participant while covered under COBRA.

b) For any Participant or Dependent covered under Section I.A.3 as a Non-Bargained Office Employee.

c) Dependents in the following categories:

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

ii. A stillborn or unborn child.

iii. An individual in whom the insurance company determines the related Participant had no insurable interest.

iv. A Participant's Dependent in the Non-Bargained Office Employee group.

v. A Dependent with COBRA continuation coverage.

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

D. 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.3:

(a) Bargained Employees

Employees of the Mid-America Carpenters Regional Council in the former geographical area of the St. Louis-Kansas City Carpenters Regional Council. 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 Participants eight (8) Hours of Approved Safety Training per year to satisfy requirements of the Mid-America Carpenters Regional Council (CRC).

The Safety Training program is administered by this Plan. Questions regarding class schedules or how to sign up should be directed to Mid-America Carpenters Regional Council Apprentice and Training Centers at 314.457.8300.

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 in adherence with the Collective Bargaining Agreements.

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 Participants.

The Trustees have contracted with St. Louis MRO to perform testing for this program.

A complete list of drug testing hours and locations may be found on our website at laborfunds.org/drug-testing or you may contact St. Louis MRO at 636.461.1300 or toll free 866.785.6761.

Section IX
Multiple Coverage Limitations

Section IX – Multiple Coverage Limitations

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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.

If the amount of Covered Charges that the Primary Plan does not pay exceeds what this Plan would have paid if it was not coordinating with the Primary Plan, this Plan will limit its payment to the amount of Covered Charges that this Plan would have paid if it was not coordinating with the Primary Plan.

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.

2. "Allowable expense" is a covered health care expense, including deductibles, Coinsurance and Copayments, covered at least in part by this Plan or another plan with which benefits are coordinated. 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 is an example 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 the primary plan provides coverage for private Hospital room expenses.

   (b) 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.

   (c) 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. This provision could apply to a married dependent.

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, Participant, policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter historical 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.

1. In determining the amount to be paid for any claim, the secondary plan will first calculate the benefits it would have paid in the absence of other health care coverage and apply that as a maximum that can be applied towards reimbursing participant cost sharing under the primary plan. If applicable, 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 under the primary plan for that claim.

2. 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.

3. If a Dependent is also covered under this Plan as a Participant, the Plan will coordinate benefits. However, the Plan will not pay more than 100% of the Allowable Expense.

   (a) **Network Provider for both Primary and Secondary Plan:** If this Plan is secondary and a provider is in-network for both the primary plan and this plan, the Allowable Expense is the primary plan's network rate. For example, if the primary plan's allowed charges are $10,000 and the Participant paid $1,000 in cost sharing, and if the secondary plan's allowed charges are $12,000 for the same in network provider, this Plan as secondary relies upon the primary plan's negotiated in-network rate. The secondary plan will use the $12,000 only to determine the maximum that secondary plan coverage might be. In this example, the covered Participant's cost sharing of $1,000 will be reimbursed by the Plan as secondary coverage.

   (b) **In-Network Provider for Primary Only:** When the provider is an in-network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. In this case, the Plan will reimburse the Participant up to its cost sharing since this plan's secondary coverage can be used to reduce cost sharing that the Participant paid to the primary plan, subject to such cost sharing being not more than what the Plan would have paid if primary.

   (c) **In-Network Provider for Secondary Plan Only** - When the provider is a non-Network provider for the Primary Plan and an in-Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. In this case, the Plan will reimburse the Participant up to its cost sharing since this plan's secondary coverage can be used to reduce cost sharing that the Participant paid to the primary plan, subject to such cost sharing being not more than what the Plan would have paid if primary.

   (d) **Non-network Provider for both Primary and Secondary Plan -** When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's reasonable and customary charges. In this case, the Plan will reimburse the Participant up to its cost sharing since this plan's secondary coverage can be used to reduce

cost sharing that the Participant paid to the primary plan, subject to such cost sharing being not more than what the Plan would have paid if primary.

(e) If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled “Determining the Allowable Expense When this Plan is Secondary to Medicare.”

The above provisions result in the coordination of benefits under this Plan reimbursing how much the Participant paid in cost sharing under their Primary Plan, but not more than this Plan would have paid had such coverage been primary under this Plan.

F. COORDINATION WITH MEDICARE-ACTIVE PARTICIPANTS AND DEPENDENTS

This Plan will be primary to Medicare for Participants 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 Participant 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 Participant in the Active Classification, and a Dependent of such Participant, who is first Entitled to Medicare because of end-stage renal disease, after 30 months of Medicare coverage.

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge if they don't accept Medicare is 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If your dependent is eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if your Dependent had enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

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 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.

CARPENTERS
BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

Section X
Third Party Liability – Subrogation and Reimbursement

Section X – Third Party Liability –Subrogation and Reimbursement

A. Generally X-1

B. Subrogation X-1

C. Reimbursement Obligation X-2

D. Duty to Notify and Cooperate with the Plan X-3

E. Right of Offset and Recovery X-5

THIRD PARTY LIABILITY – SUBROGATION AND REIMBURSEMENT

A. GENERALLY

1. If a Covered Person sustains an Injury or Illness 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 Illness, except as provided in this Section.

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 Illness, 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 Illness 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 Illness 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 Illness, 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 Illness while covered under the Plan, the provisions of this Section 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 Illness, 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 Illness.

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 Illness 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 Illness 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 Illness, 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 Participant of the group to which the Covered Person belongs that consists of a Participant of this Plan and the Participant's Dependents.

(f) A Participant is responsible for performing all obligations of a Covered Person who is the Participant'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, or if the Plan compromises its lien or is reimbursed for less than all such benefits paid, then the Plan is thereafter not obligated to pay additional benefits on account of the same Injury or Illness until the sum of all benefits paid and claimed for that Injury or Illness 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 Illness 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 Illness 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 Participant (if the Participant 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 Illness 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 Illness, or any claim which he or she asserts against a third party on account of an Injury or Illness 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 Illness 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 Participant and his or her eligible Dependents. The Trustees may also bring legal action against the Participant 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 Participant 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
CLAIMS AND APPEALS PROCEDURE

Section XI – Claims and Appeals Procedure

A. Generally XI-1

B. Filing a Claim XI-1

C. Notification of Initial Benefit Determination/Appeals XI-3

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 UMR Claims Appeal Unit ("CAU"), as designee of the Plan's Board of Trustees. In addition, a Claimant will have opportunity to seek review of UMR'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 XI, 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 www.umr.com 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(m)(8).

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. For claims where we are the secondary payer, claims should be filed within 180 days. 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:

UMR
PO Box 30541
Salt Lake City, UT 84130-0541

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 of 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 laborfunds.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 laborfunds.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 of 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 Benefit 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 XI, 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 Benefit 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(m)(8), to the Claimant's claim.

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

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. With respect to initial Adverse Benefit Determinations for claims for medical, prescription, dental, or vision benefits, there are two mandatory appeals: the first appeal shall be decided by the applicable network partner identified below, and the second appeal shall be decided by the Board of Trustees. With respect to initial Adverse Benefit Determinations for claims other than for medical, prescription, dental, or vision benefits, the only appeal shall be to the Board of Trustees. The Board of Trustees may delegate authority to decide Appeals to an Appeals Committee consisting of members of the Board of Trustees. A Claimant must exhaust all internal appeals before brining a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA").

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

All requests for Appeal of an initial Adverse Benefit Determination with respect to a medical claim (including all relevant information) must be submitted to the following address:

First-level Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546
Send first-level Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

All requests for Appeal with respect to a dental claim (including all relevant information), must be submitted to the following address:

Delta Dental of Missouri
Attn: Appeals Committee
12399 Gravois Road
St. Louis, MO 63127-1702

All requests for Appeal with respect to a prescription drug claim (including all relevant information), must be submitted to the following address:

Express Scripts
ATTN: Clinical Appeals Department
PO BOX 66588
St. Louis, MO 63166-6588
Fax 1.877.852.4070
Phone: (800) 753-2851

All requests for Appeal with respect to a vision claim (including all relevant information), must be submitted to the following address:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

All other requests for Appeal of an initial Adverse Benefit Determination (including all relevant information), 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

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.

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(m)(8), to the Claimant's claim for benefits.

10. **Manner of Deciding Appeals**

An Appeal will be considered and decided, without deference to the adverse initial benefit determination, by individuals 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 Plan or its agent 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 Plan or its agent 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.

The Plan or its agent 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 Claims

The Plan or its agent shall notify the Claimant of the Plan's decision on Appeal of a pre-service 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 Claims

The Plan shall make a decision on Appeal of a 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 the request for review.

(d) Disability Claims

The Plan shall make a decision on Appeal of a disability claim no later than the date of the meeting of the Appeals Committee that immediately follows the Plan's receipt of a request for Appeal, unless the request for Appeal is filed within 30 days preceding the date of such

meeting, in which case a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for Appeal. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Appeals Committee. If such an extension of time for review is required because of special circumstances, the Plan will notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to commencement of the extension.

(e) 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.

(f) 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(m)(8), 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. If the appeal concerns any adverse benefit determination that is based in whole or in part on a medical judgement, 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) Pre-Service 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) Post-Service Claim: The Plan shall make a decision on a second level appeal of a post-service claim no later than the date of the meeting of the Appeals Committee that immediately follows the Plan's receipt of a request for Appeal, unless the request for Appeal is filed within 30 days preceding the date of such meeting, in which case a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for Appeal. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Appeals Committee. If such an extension of time for review is required because of special circumstances, the Plan will notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to commencement of the extension.

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 Benefit 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. **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.

Appendix I

GENERAL PLAN DEFINITIONS

Unless indicated otherwise in a specific context, words used in this booklet shall have the meanings set forth in this Appendix I. 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. **"Active Classification"** as defined in Section I.C.1.
2. **"Active Work"** means the performance of work as an Eligible Member at such place as is required in the course of his employment.
3. **"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.
4. **"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.
5. **"Bargained Employee"** refers to those individuals represented by a collectively bargained agreement with negotiated contributions paid by employers to this Plan
6. **"Basic Plan"** refers to the health benefits offered to an eligible Union Member during the first four terms of apprenticeship, for those attaining initial eligibility on and after July 1, 2023. Health benefits refer to medical, prescription, dental and vision coverages. The Basic Plan includes the same coverage for life insurance as the Premium Plan.
7. **"Benefit Quarter"** means any of the three-month periods beginning January 1, April 1, July 1, and October 1 of each year.
8. **"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 Construction Trades Open End Pension Trust Fund or the Carpenters Pension Fund of Illinois (Geneva).
9. "**Child**" is defined in Section I.D.3.
10. **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.
11. **"Coinsurance"** is the percentage amount you must pay for a service or supply as defined by the benefit schedule.
12. **"Collective Bargaining Agreement"** is the written legal contract between the Mid-America Carpenters Regional Council and an Employer.
13. **"Contribution Quarter"** means any of the three-month periods beginning February 1, May 1, August 1, and November 1 of each year.
14. **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.
15. **"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 Illness 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.

16. **"Covered Lives"** are Participants and their covered Dependents, who are eligible for benefits under the Plan in accordance with the Eligibility Section of this document.

17. **"Credit Hour"** means all the following:

(a) Each hour for which a Participant is directly or indirectly paid by a Participant'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 Participant is directly or indirectly entitled to payment by a Participant's Employer for which contributions are due but not paid, yet for which satisfactory proof a Participant (excluding a Participant 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 Participant 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.

18. **"Deductible"** refers to the amount of money a Participant will need to pay before the Plan will start paying benefits on claims incurred.

19. **"Dependents"** refer to legal spouses and children of Participants, who are eligible for benefits under the Plan in accordance with the Eligibility Section of this document.

20. **"Eligibility Class"** means the category or class which a Covered Person becomes qualified and maintains coverage.

21. **"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.

22. **"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.

23. **"Employee"** refers to those employees of an Employer with a signed participation agreement.

24. **"Employer"** means Employer as defined in the Carpenters' Health and Welfare Trust Fund Agreement.

25. **"Enrollment Form"** is the required application for enrollment in the Plan.

26. **"Entitled to Medicare"** means an individual is both Eligible for Medicare and enrolled in any part of Medicare.

27. "**ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

28. **"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.

29. **"Full Contribution Rate"** means the current Journeyman hourly rate specified in the Collective Bargained Agreement under which most contributions are paid. This rate is subject to change from time to time as determined by the Trustees and announced by the Plan.

30. **"Full Credit Hours"** refers to those hours credited and paid under the Full Contribution Rate per hour. Any Credit Hour paid at less than the full contribution rate does not count towards the Full Credit Hours. Full Credit Hours apply for the purpose of the Plan Year eligibility provision.

31. **"Grandfathered In House Employees"** For purposes of eligibility in the Plan, employees hired prior to January 1, 2024, will be considered **Grandfathered Non-Bargained In-House Employees** where hourly contributions are required to this Plan.

32. **"Illegal Activity"** is any felony or misdemeanor, or any other activity which is against civil or criminal law for which the Participant was charged or arrested and is expected to be convicted.

33. **"Illness"** 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 Illnesses that are due to the same or related cause or causes will be deemed one Illness.

34. **"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.

35. **"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.

36. **"Medical Care Management"** means the services provided by the Plan to assist Participants and their families to receive medical care, services, and supplies in the event of a catastrophic Illness or Injury.

37. **"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.

38. **"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.

39. **"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.

40. **"Non-Active Classification"** is defined in Section I.C.2.

41. **"Non-Bargained Employee"** refers to employees of the Fund participating in the Plan.

42. **"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.

43. **"Non-Pension Participant"** means a Participant 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 Mid-America Carpenters Regional Council, like a participation agreement or a collective bargaining agreement.
44. **"Open Enrollment"** means the time or times during the year when an employee may normally enroll for coverage in an Employer-sponsored health plan.
45. **"Out-of-Network"** or **"Non-Network Provider"** means a health care provider who is not contracted with one of the Plan's Network Sponsors.
46. **"Out-of-Pocket Maximum"** is the maximum amount Participants 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.
47. **"Participant"** refers to those 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. Participants eligible are enrolled in coverage subject to any required documentation and any premiums owed for Non-Active Classifications.
48. **"Participation Agreement"** is a signed agreement between this Plan and the entity making contributions to this Plan, subject to Trustee approval.
49. **"Part-Time"** is defined as an employee who on average works less than 30 hours per week.
50. **"Pharmacy Benefit Manager and Network Sponsor"** means the organization with whom the Plan has contracted with to administer the Prescription Drug Program.
51. "**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.
52. **"Plan Year"** shall commence on May 1 of one year and end on April 30 of the succeeding year.
53. **"Post-Service Claim"** is an Appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
54. **"Premium"** is the monthly fee required for certain classes of coverage under the Plan.
55. **"Premium Plan"** refers to the health benefits offered to Participants and their Dependents, other than Apprentices in their first through fourth term covered in the Basic Plan. Health benefits under the Premium Plan include medical, prescription drugs, dental, vision and disability coverages. Life insurance benefits are the same for all Participants.
56. **"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.
57. **"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.

58. **"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.

59. **"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 Participant 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 Participant'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.

60. **"Qualifying Event"** means "qualifying event" as defined in Section I.E.1.

61. **"Qualified Beneficiary"** means "qualified beneficiary" as defined in Section I.E.2.

62. **"Retired Participant"** means a **"**retired Participant" as defined in Section I.C.2.(f).

63. **"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.

64. **"Signatory Employers"** means an employer who is obligated by a Collective Bargaining Agreement to make Health and Welfare contributions to this Plan.

65. **"Special Organizing Group"** means any group of Participants joining the union under special provisions related to payments or hourly rates to participate in any benefits herein.

66. **"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.

67. **"Spouse"** means "spouse" as defined in Section I.D.2.

68. **"Total Disability"** means complete inability of the Participant or Covered Dependent to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Participant 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 Participant. In the case of a covered child dependent, such determination relies upon the definition of disability under the Social Security Administration that also results in coverage under Medicare as a result of such disability.

69. **"Totally and Permanently Disabled"** means a Participant or Covered Dependent 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.

70. **"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.
71. **"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.
72. **"Trustees"** shall mean the Trustees under the Trust Agreement

Appendix II

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 St. Louis-Kansas City Carpenters Regional Health Plan, 1419 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 Participants in amounts determined by the Trustees. Contributions are made to the St. Louis-Kansas City Carpenters Regional Health Plan, 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 illness, 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 Mid-America Carpenters Regional Council. 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: Mid-America Carpenters Regional Council 1401 Hampton Avenue St. Louis, Missouri 63139 Telephone: 314-644-4800 Toll free: 800-332-7188 info@carpentersunion.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: St. Louis-Kansas City Carpenters Regional Health Plan 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.

Network Partners

Medical Benefits
UMR
P.O. Box 8046
Wausau, WI 54402
Website: **www.UMR.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**

Prescription Drug Benefits
Express Scripts
100 Parsons Pond Drive
Franklin Lakes, New Jersey 07417
Website: **www.express-scripts.com**

Specialty Prescription Drug Benefits
Accredo Pharmacy
PO Box 954041
St Louis, MO 63195
Website: **www.accredo.com**

Vision Benefits
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 May 1, 2024.

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

Union Trustees	Employer Trustees
Gary Perinar, Chairman of the Board 12 E Erie St Chicago, IL 60611	Craig McPartlin, Secretary of the Board Con-Tech Carpentry 366 W. Fourth St. Eureka, MO 63025
Stephen Pinkley STL Regional Director 1401 Hampton Avenue St. Louis, MO 63139	Kevin Deptula Builders Bloc 607 Trade Center Blvd. Chesterfield, MO 63005
Rocky Kloth KC Regional Director 8955 E. 38th Terrace Kansas City, MO 64129	Gerhard K. Glassl The Up Companies 2060 Craigshire Rd. St. Louis, MO 63146
Dan Barger SO IL Regional Director 1401 Hampton Avenue St. Louis, MO 63139	Brian Murphy BAM Contracting LLC 2342 LaSalle St. St. Louis, MO 63104
Kevin Haynes 1401 Hampton Avenue St. Louis, MO 63139	Jim Sauer Fixture Contracting Retired
Mark Dalton 1401 Hampton Avenue St. Louis, MO 63139	Timothy Schoolfield Countryside Carpets and Interiors, Inc. 1305 Tom Ginnever Ave. O'Fallon, MO 63366
Mike Gavoli 8955 E. 38th Terrace Kansas City, MO 64129	Rick Kayser Alberici Constructors, Inc 8800 Page Avenue St. Louis, MO 63114
Rodney Politte 1401 Hampton Avenue St. Louis, MO 63139	Scott Plocher Plocher Construction Co., Inc. 2808 Thole Plocher Rd. Highland, IL 62249

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.

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, 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.

Use and Disclosure of Protected Health Information

It is the intent of this Plan to be in compliance with the Health Insurance Portability and Accountability Act of 1996 and the Regulations issued by the Secretary of Health and Human Services (together referred to herein as the Privacy Rule). The Privacy Rule is incorporated herein by reference. This section establishes the required and permitted uses and disclosures of Protected Health Information (PHI) by the Plan Sponsor, which is the Board of Trustees.

PHI may be used by and disclosed to the Board of Trustees or individual Trustees for purposes of general administration of the Plan, as follows: (1) Underwriting and budgeting, (2) Claims review and processing, (3) Amending or modifying the Plan of Benefits, (4) Claims assistance, (5) Eligibility review, (6) Any and all general administration of the Plan.

PHI may be disclosed to the Board of Trustees, or individual Trustees, as authorized by an individual.

The Plan shall make reasonable efforts to limit disclosure and use of PHI to the Board of Trustees to the minimum necessary to accomplish the intended use or disclosure.

The Board of Trustees shall: (1) Not use or further disclose PHI other than as permitted or required by this Plan or as required by law; (2) Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information; (3) Not use or disclose information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees; (4) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for or which it becomes aware; (5) Make available PHI in accordance with 45 C.F.R. § 164.524; (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526; (7) Make available the information required to be provide an accounting of disclosures in

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 a 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 a suit in a state or federal court after you exhaust all administrative procedures and appeal processes set forth in the Plan. 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 a 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.

Appendix III - Summary Grid of Eligibility Coverage

	MEDICAL BENEFIT	PRESCRIPTION BENEFIT	DENTAL BENEFIT	VISION BENEFIT	WELLNESS CENTER
ACTIVE CLASSIFICATION					
Bargained Employees (1st - 4th Term Apprentices) and Dependents	Basic Plan	√	Basic Plan	Basic Plan	√
Bargained Employees (5th - 8th Term Apprentices - Journeymen) and Dependents	Premium Plan	√	Premium Plan	Premium Plan	√
Non-Bargained Office Employees and Dependents	Premium Plan	√	Premium Plan	Premium Plan	√
Non-Bargained In-House Employees and Dependents	Premium Plan	√	Premium Plan	Premium Plan	√
COBRA Participants*	Plan at termination	√	Plan at termination	Plan at termination	√
*The Premium vs Basic Plan for COBRA Participants is determined by the applicable plan at the time of the loss of coverage					

	MEDICAL BENEFIT	PRESCRIPTION BENEFIT	DENTAL BENEFIT	VISION BENEFIT	WELLNESS CENTER
WELLNESS CENTER					
Retired/Disabled Participants* **	√	√	√ If elected	√	Non-Medicare
Surviving Spouse Participants and Dependents*	√	√	√ If elected	√	Non-Medicare
*A Non-Active Participant who becomes eligible for Medicare will be covered by the United HealthCare Medicare Advantage Plan for medical and vision **Certain Retired and Disabled participants who lost coverage and were reinstated are not eligible for Life Insurance and Accidental Death & Dismemberment Benefits					

Appendix III - Summary Grid of Eligibility Coverage, cont.

	SHORT-TERM DISABILITY BENEFIT	LIFE INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT
ACTIVE CLASSIFICATION			
Bargained Employees (1st - 4th Term Apprentices) and Dependents	NA	√	√ Participant Only
Bargained Employees (5th - 8th Term Apprentices - Journeymen) and Dependents	√ Participant Only	√	√ Participant Only
Non-Bargained Office Employees and Dependents	NA	NA	NA
Non-Bargained In-House Employees and Dependents	√ Participant Only	√	√ Participant Only
COBRA Participants*	NA	NA	NA
*The Premium vs Basic Plan for COBRA Participants is determined			

	SHORT-TERM DISABILITY BENEFIT	LIFE INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT
WELLNESS CENTER			
Retired/Disabled Participants* **	NA	√	√ Participant Only
Surviving Spouse Participants and Dependents*	NA	√	NA
*A Non-Active Participant who becomes eligible for Medicare will b			
**Certain Retired and Disabled participants who lost coverage and			

LABORFUNDS.ORG

CONTACT US

Local: 314-644-4802
Toll-free: 877-232-3863
Email: benefits@laborfunds.org
Mid-America Carpenters Regional Benefit Services
1419 Hampton Ave
St. Louis, MO 63139