MID-AMERICA
CARPENTERS BENEFITS

MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND

STLKC SOUTHERN REGION

SUMMARY PLAN DESCRIPTION

EFFECTIVE JULY 1, 2025

laborfunds.org/health-plan

Mid-America Carpenters Regional Council Health Fund

Summary Plan Description for the Southern Region Benefit Plan

July 1, 2025

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A MESSAGE FROM THE TRUSTEES

It is very important that our Participants and family members are provided with quality, affordable health care. It's equally important that you know what benefits are available to you and how to use them to your best advantage—both financially and for your health.

This Summary Plan Description or SPD is given to all of our Participants and their family members as a reference document and a resource you can use to become better acquainted with your benefits and the processes involved in using them. It is meant to be easy to read and understand. When we use the word "he," it refers to both genders throughout the SPD. We have tried to present the information in a straightforward and logical way.

While we have made an effort to explain things in everyday language, you may come across some words and phrases that have specific meaning within the context of the Plan. To help you understand them, they are capitalized throughout the SPD and their definitions are found in Appendix I that starts on page 116.

As always, our Benefit Office remains ready to serve you and your family, answering questions and providing updates on our benefits as they occur. The Benefit Office address and contact information are:

1419 Hampton Avenue
St. Louis, Missouri 63139
Telephone: 314-644-4802
Toll Free: 877-232-3863
benefits@laborfunds.org

Here's to your very good health and wellness, now and in the future.

The Board of Trustees

ABOUT THIS BOOKLET

This booklet provides you with a summary of the Mid-America Carpenters Regional Council Health Fund - Southern Region Benefit Plan of Benefits (the "Plan") as of July 1, 2025, and replaces and supersedes any prior Summary Plan Descriptions (SPDs). It does not contain all Plan details. In determining any aspect of Plan coverage, the full provisions of the formal Plan Documents always govern. You may obtain a copy of those documents by making a written request to the Plan Administrator. The Trustees reserve the right to change benefits in any way or terminate the Plan or any part of the Plan at any time, as allowed under law.

Highlights of eligibility requirements and Plan coverage begin on page 3. You can find the *Schedules of Benefits* that summarize your Plan benefits beginning on page 139. Plan highlights that include the items listed below start on page 25.

- Detailed benefits coverage;
- Limits and exclusions
- How to file Claims and appeals; and
- Other administrative Plan information.

Certain terms used in this document have specific meanings within the context of the Plan and are defined in Appendix I that starts on page 116.

NOTIFY US IF: If you have a change in status, you must notify the Benefit Office at 314-644-4802, within 90 days of that change to update your information. Failure to report certain events could result in delayed eligibility status for your Dependents. Changes in status include:

- Change of address
- Marriage (you may also want to change your beneficiary)
- Changes in Dependent eligibility, or if you have a baby, adopt a child or become a stepparent
- Death of a Dependent (you will also want to file a claim for Life Insurance benefits and/or change your beneficiary)
- Adding or dropping other insurance coverage, including becoming eligible for coverage with Medicare or Medicaid.

You must notify the Benefit Office within 60 days of the following events, in order to avoid forfeiting continuation of coverage rights under COBRA:

- A divorce or legal separation; or
- When your Dependent child no longer meets the Plan's definition of a Dependent.

INTRODUCTION

The Health Fund (the "Fund") provides comprehensive health care coverage for you and your family through the Plan. The Fund contracts with professionals to offer you in-network access to quality care at reduced costs. Plan health benefits include:

- Comprehensive Medical Benefits, which include preventive care, Doctor Office Visits, Hospital care (inpatient and outpatient) and hearing assessments. Comprehensive Medical Benefits are provided through a Network of providers administered by the Fund's Contracted Provider, UMR.

- The Carpenters Wellness Centers, which offer access to health and wellness services.

- Mental health/substance use disorder treatment services provided through UMR Network providers and the Mercy Member Assistance Program.

- Prescription drug benefits are provided through the Express Scripts Inc. (Express Scripts) pharmacy network and specialty drug benefits are provided through Accredo Specialty Pharmacy.

- Access to vision benefits is offered through Vision Service Plan's network of providers.

- Access to dental benefits is offered through Delta Dental of Missouri.

In addition, the Plan includes:

- Short Term Disability benefits, which provide a weekly benefit if you are Disabled due to an Illness or Injury and can't work, and Maternity Leave Benefits for certain pregnant employees who are unable to work, see page 82 for details.

- Life and Accidental Death and Dismemberment (AD&D) Insurance benefits offered through an insurance contract with Metropolitan Life Insurance Company (MetLife) as added financial protection for your family.

The benefits listed above apply to Participants who meet the eligibility requirements as described beginning on page 3. Certain Apprentices may have different coverages. See page 3 for details.

If you lose your eligibility for coverage under the Plan, various continuation of coverage options are available to you. For more details, see the sections titled Minimum/Difference Self Payments and COBRA Continuation Coverage, beginning on pages 8 and 19 respectively.

ELIGIBILITY & ENROLLMENT

This section sets forth the rules for determining eligibility for all benefits under the Southern Region Benefit Plan.

A. ELIGIBLE GROUPS

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

1. Bargained Employees
2. Non-Bargained Office Employees
3. Non-Bargained In-House Employees
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.

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

B. APPLICABLE BENEFIT PLAN

Premium Plan

All eligible Participants, other than those described below, are enrolled as a Participant in the Premium Plan.

Basic Plan

Apprentices who initially qualify for the Active Classification on or after July 1, 2023, and are determined, as applicable, by the Union 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 Plan.

Once a Participant in the Basic Plan is upgraded to Fifth Term Apprentice status as determined by the Union or Apprentice and Training Fund or its successor, the Participant will be moved to the Premium Plan effective as of the date the Plan receives notice of the upgrade.

C. ELIGIBILITY – 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).

There are two Eligibility Classes under the Active Classification:

1. **Hours-Based Eligibility** for Bargained Employees and Grandfathered In-House Employees who receive Credit Hours based on Employer contributions under either a CBA or Participation Agreement.

2. **Monthly Eligibility** for Non-Bargained Office Employees and Non-Bargained In-House Employees on whose behalf the Plan receives the required monthly Employer contribution and Self-Employed individuals who submit the required monthly self-pay contribution.

Initial Eligibility – Hours-Based Eligibility

Initial eligibility requires working 300 Credit Hours in a rolling three-month period. An Employee will have coverage effective the first day of the month following completion of 300 Credit Hours in a rolling three-month period. Initial coverage will continue for two Benefit Quarters provided the Employee continues to work an average of 300 hours within a rolling three-month period. For the third Benefit Quarter, the Employee must meet the Continuing Eligibility Rules.

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.

An Employee of an Employer may be given immediate Eligibility for a limited period of time by receiving the applicable contributions for such immediate coverage pursuant to a written agreement as approved by the Union and the Trustees.

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**

Initial Eligibility - Monthly Eligibility

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

Continuing Eligibility – Hours Based Eligibility

For continuing Hours-Based Eligibility, the Plan has the concepts of fiscal Contribution Quarters and calendar year Benefit Quarters. Once enrolled in the Plan, a Participant will continue coverage by meeting one of the following Continuing Eligibility rules:

1. **Quarterly Rule**: Receipt of 330 Credit Hours in a Contribution Quarter 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

2. **Look Back Rule**: Receipt of at least 1400 credit hours during the four 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	1,400	May June	July August September
August – July	1,400	August September	October November December
November – October	1,400	November December	January February March
February – January	1,400	February March	April May June

3. **Plan Year Rule**: Receipt of at least 1560 uncapped Credit Hours in the prior May – April and the Participant's employer contributes the full, unsubsidized Journeyman rate for health benefits, will extend eligibility from July 1 through December 31 of the same year.

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

4. **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 will be automatically continued, without contributions, until the earlier of:

(a) The end of the Benefit Quarter associated with the Contribution Quarter in which the Participant's Total Disability ends,

(b) The end of the Benefit Quarter associated with the Contribution Quarter in which the Participant returns to work, or

(c) The end of the Benefit Quarter contains the first anniversary of the date the Participant's Total Disability began.

Continuing Eligibility – Monthly Eligibility

Coverage will continue month-to-month provided the Fund timely receives the required contribution on the Participant's behalf. The monthly contribution maintains the Participant's eligibility for the following month.

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:

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

2. 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.)

3. The date of the Participant's death.

4. 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.)

5. 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.

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

7. 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.

Reinstatement of Coverage

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

1. **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 Participant must satisfy the Initial Eligibility requirements.

2. **Monthly Eligibility Class**: The Participant's coverage will be reinstated on the first day of the month following the month in which the required monthly contribution is received by the Plan.

Minimum/Difference Self-Payments

A Participant who is a Bargained Employee or Grandfathered In-House Employee who is losing eligibility in the Active Classification may elect to maintain continuous Active Classification coverage by making a Minimum/Difference self-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.

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 multiplied by the Full Contribution Rate.

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

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

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. 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.

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

1. The date the Participant's maximum period of Minimum/Difference coverage ends;

2. The last day of the Benefit Quarter for which the Participant made a timely payment;

3. The end of the Benefit Quarter in which the Participant first becomes Eligible for Medicare;

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

5. The date of the Participant's death;

6. 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

7. The date the Plan terminates.

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.

Notwithstanding the forgoing, the following Participants are not eligible to continue coverage through Minimum/Difference Payments:

8. 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.

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

10. 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.

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

12. Participants who have already elected and commenced COBRA continuation coverage.

13. Participants who are currently covered via the Initial Eligibility rules.

D. ELIGIBILITY – NON-ACTIVE CLASSIFICATION

Bargained Employees, Non-Bargained In-House Employees, and Self-Employed Employees may continue coverage under the Plan through self-payments after they no longer meet the requirements of the Active Classification due to retirement or disability. Surviving Spouses may also continue coverage under the Plan through self-payment.

Non-Active Classification Benefits

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

1. Covered Persons who are eligible for Medicare are eligible only for the Medicare Advantage Program and, if enrolled in the Medicare Advantage Program, the Dental benefit and the Life benefit. Medicare-eligible Participants enrolled in the Medicare Advantage Program are also eligible for the Accidental Death and Dismemberment benefit.

2. Disabled Participants are not eligible for Short-Term Disability benefits

3. Participants and Surviving Spouses have the option to enroll in Dental benefits for an additional Premium upon becoming eligible for the Non-Active Classification.

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 as follows

1. A Spouse who opted out of coverage in this Plan can later enroll in the Plan provided the Spouse maintained continuous health coverage through their employer and that coverage did not terminate more than 63 days before the requested date for beginning Non-Active coverage in the Plan, or

2. A newly acquired Dependent can request enrollment within 30 days of a special enrollment event (see below).

Self-Payment Premium Requirements

Participants and Surviving Spouses must make timely monthly self-payment Premium payments directly to the Plan. The Premium amount shall be 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 timely.

Carpenters Regional Council Affiliation Requirement

As a condition of eligibility for benefits under the Non-Active Classification, all Participants except Non-Bargained In-House Employees must maintain membership with the Union or its affiliated Locals at all times.

Medicare Eligible Participants and Dependents: UHC Medicare Advantage Program

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 remain covered by the Plan, the Participant or Dependent must enroll in the UHC Medicare Advantage Program.

The UHC Medicare Advantage Program fully insured by UnitedHealthcare and provides Medicare Part C & Medicare Part D benefits. 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. 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 the Participant has elected family coverage.

While covered in the Active Classification, Participants or Dependents are not eligible to enroll in the UHC Medicare Advantage Program unless they qualify and become covered in the Non-Active Classification.

Retired Participants

A Retired Participant first becomes eligible for the Non-Active Classification 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 the Non-Active Classification at the end of such extended period of Active Classification coverage.

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

1. The Participant elects such coverage within 63 days after first becoming eligible; and

2. Has at least 120 months, in any combination, of:

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

(b) Months of Active Classification coverage, excluding Non-Bargained Office Employee coverage, or

(c) Months of coverage in the Monthly Eligibility Class associated with Non-Bargained In-House Employees; and

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

A Bargained Participant who loses Active eligibility as a result of acquiring employment in a non-bargained position by an Employer, and who remains covered in a group health plan by that 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:

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

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

6. Has at least 120 months, in any combination, of:

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

(b) Months of Active Classification coverage, excluding Non-Bargained Office Employee coverage.

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

Retired Self-Employed Participants & Non-Pension Participants

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.

1. The Participant must attain age 55; and

2. The Participant must permanently cease all employment and inform the Plan in writing; and

3. The Participant must have at least 120 months in any combination of:

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

(b) Months of Active Classification coverage, excluding Non-Bargained Office Employee coverage; and

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

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:

1. 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

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

3. The Participant has at least 120 months, in any combination, of:

   (a) Months in which the Participant performed bargaining unit work for an 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

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

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

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.

Coverage in the Non-Active Classification 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 above in the Reinstatement Provisions.

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:

1. 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

2. 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 an 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

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

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.

Retired Participants Working in the Non-Active Classification

Participants covered in the Non-Active Classification, other than Disabled Participants, Retired Self-Employed, and 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 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.

Notwithstanding the foregoing, a Participant enrolled in the Medicare Advantage Program who receives sufficient health Credit Hours to reinstate Active coverage will reestablish coverage in the Active Classification.

Termination of Non-Active Classification Eligibility

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

1. In case of non-payment of the monthly contribution or payment received after the grace period, the end of the last month for which timely payment was received.

2. The date of the Participant's death.

3. 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.

4. 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.

5. The date the Plan terminates.

E. 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 or Non-Bargained Office Employee coverage. Dependents of Participants in the Non-Active Classification are covered only if the Participant has elected family coverage. 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.

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 becomes eligible, or 90 days in the case of a newborn Dependent, 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.

Working Spouse Rule

During any period when an Active Participant's Spouse is employed as a full-time employee (as defined in Internal Revenue Code section 4980H) and eligible to participate in a Qualified Plan, the Spouse must enroll in the Qualified Plan in order to be eligible for benefits in this Plan as a Dependent. This rule does not apply to self-employed Spouses or Spouses that are enrolled in other non-employer sponsored coverage that would pay primary to this Plan.

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. Such verification may be requested at any time.

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.

A Spouse's coverage under this Plan will terminate if the Spouse fails to enroll in a Qualified Plan when eligible, or if the Participant, Spouse or Spouse's employer fails to provide required information requested by the Plan. Failure to enroll or comply with required information requested by the Plan is not a COBRA qualifying event. If the Spouse thereafter enrolls in a Qualified 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. 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.

In cases where the Spouse is given a choice of plan designs by the employer, a working Spouse must 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. If the Spouse's employer offers only a high-deductible health plan, the Spouse must enroll in that plan. A Spouse is not required to elect dental or vision benefits, or family coverage.

In cases where Spouse is 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.

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.

Special Definitions

For purposes of the working spouse rule, the following definitions apply:

1. A "Qualified Plan," is a plan that:

   (a) Is insured, or self-insured by the Spouse's employer, and subject to regulation by state or federal agencies such as the US Department of Labor or Internal Revenue Service;

   (b) Offers industry recognized standard benefits for medically necessary hospitalization, surgery and outpatient medical treatment and prescription coverage;

   (c) The Spouse's employer contributes toward the cost of coverage (i.e., the Spouse is not required to pay 100% of the premium).

2. "Required Information" means the information required by the Trustees to establish an Active Participant Spouse's eligibility for the Plan, including a complete response from a Participant and Spouse to an information request from the Plan, and written verification from the Spouse's employer.

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 remains 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.

Special Enrollment

If a Participant acquires a new spouse and stepchildren through marriage the Participant shall enroll such new Dependents within 30 days after the date of the marriage. If timely proof of Dependent status is received by the Benefit Office, coverage is retroactively granted to the date the new Dependent is acquired. If timely proof of Dependent status is not provided within this 30-day period, coverage shall effective as of the date Benefit Office receives the required documentation.

If a Participant acquires a new Dependent child through birth, adoption or placement for adoption, the Participant shall enroll such Dependent child no later than 90 days after the date of birth or date of adoption or placement for adoption, of the child. If timely proof of Dependent status is received by the Benefit Office, coverage is retroactively granted to the date the new Dependent is acquired. If timely proof of Dependent status is not received within this 90 day period, coverage shall be effective as of the date the Benefit Office receives the required documentation.

If an Employee did not enroll any Dependent (including Spouse) when the Employee's Dependent first became eligible for such coverage under the Plan because the Dependent had health coverage under another group health plan or health insurance policy, and subsequently the Dependent loses coverage under such other group health plan or health insurance policy, the Employee may enroll the Dependent child in the Plan within 31 days after the termination of coverage under such other

group health plan or health insurance policy. The Fund will require evidence that the other coverage has terminated.

If an Employee did not enroll any Dependents when the Dependent first became eligible for such coverage under the Plan because the Dependent had other coverage under Medicaid or the State Children's Health Insurance Program ("CHIP"), and the Dependent loses eligibility for that coverage, the Employee may enroll the Dependent in the Plan within 60 days of the loss of such coverage.

If an Employee did not enroll any Dependents when the Dependent first became eligible for such coverage under the Plan, and the Dependent becomes eligible for financial assistance through Medicaid or CHIP for coverage under the Plan, the Employee may enroll the Dependent in the Plan within sixty (60) days of becoming eligible for financial assistance through Medicaid or CHIP.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) or National Medical Child Support Notice, as defined under ERISA, means a court order requiring a medical plan to provide medical benefits to the children of parents seeking a divorce or other state domestic relations actions where financial support of children is involved.

A child covered under a QMCSO or a National Medical Support Notice will be enrolled as a Dependent under the coverage option in which you are enrolled. The Plan will not terminate an eligible Dependent's coverage when the child is covered by a QMCSO.

Contact the Benefits Office at 314-644-4802 to request a copy of the Plan's QMCSO procedures free of charge or visit the Plan's website at benefits@laborfunds.org.

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:

1. The date the Participant's eligibility ends.

2. The date the individual no longer qualifies as an eligible Dependent under the terms of the Plan. For purposes of a Participant's Spouse, the Spouse no longer meets the requirements of a Dependent upon divorce, annulment of marriage, or legal separation. 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.

3. The date the Non-Active Classification Participant becomes Entitled to Medicare unless the Participant enrolls in the Medicare Advantage Program.

4. 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:

(a) The Dependent of 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

5. 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.

6. The date the Participant fails to provide supporting enrollment documentation as requested by the Plan.

7. 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.

8. The date of the Participant's death. However, an Hours-Based Eligibility Participant's Dependents will remain covered until the end of the third month after the month of the Participant's death or, if later, until the end of the eligibility period earned by the Participant's Credit Hours as of the date of death. The Surviving Spouse may be eligible to elect Non-Active Classification Benefits thereafter.

9. The date the Plan terminates.

F. COBRA CONTINUATION COVERAGE

The Fund provides health care continuation coverage under COBRA for qualified beneficiaries whose coverage under the Plan would otherwise end because of your termination of employment, death or certain other qualifying events. If you and/or your qualified beneficiary's coverage under the Plan terminates, you or your qualified beneficiary may choose to pay for and receive full or limited health coverage under the Active Plan. Continuation coverage under COBRA does not include Short Term Disability, Life Insurance or AD&D Insurance coverage.

A qualified beneficiary under the Plan means you, your spouse (or your former spouse, legally separated spouse or surviving spouse) or your Dependent who is covered under the Plan on the day before a qualifying event and whose health care coverage would otherwise end upon the occurrence of a qualifying event.

A new spouse or Dependent child born to you, adopted by you or placed for adoption with you during your period of continuation coverage under COBRA is also considered a qualified beneficiary. You must notify the Benefits Office, in writing, and provide documentation verifying the marriage, birth, adoption or placement of a child with you for adoption to have this child added to your continuation coverage under COBRA. An additional premium may apply.

One or more of the qualifying events listed below entitles you and/or your qualified beneficiaries to elect continuation coverage under COBRA and it meets one or more of the following:

- Termination of your employment (for causes other than gross misconduct);

- Reduction in your work hours;

- Your death;

- You and your spouse becoming legally separated or divorced;
- Your child loses Dependent status under the Plan; or.
- You become entitled to, or eligible for and enroll in Medicare coverage (and your Dependents then lose Plan coverage).

COBRA coverage is offered for the continuation periods shown in the chart shown below.

Qualifying Event	Qualified Beneficiaries	Maximum Coverage Period
Your termination of employment or a reduction in hours worked	You Your spouse Your Dependent child	18 months
Your death	Your spouse Your Dependent child	36 months
Divorce or legal separation	Your spouse Your Dependent stepchild	36 months
Your child no longer qualifies as a Dependent child under the Plan	Your Dependent child	36 months

Disability Extension

If you or a covered Dependent enrolled in continuation coverage under COBRA, are subsequently determined by the Social Security Administration to be disabled and you notify the Benefit Office, you and your entire family may be entitled to receive up to an additional 11 months of continuation coverage under COBRA, for a total of 29 months. You must notice the Benefits Office within 60 days of receiving the disability award notice from the Social Security Administration, and before the end of the 18-month COBRA coverage period.

General Rules

The Fund has developed a notice and election procedures in accordance with COBRA as follows:

1. The Trustees will provide written notice of the provisions of continuation coverage under COBRA to you and your covered Dependents within 90 days of the date coverage under the Plan begins or within 90 days of a significant change in procedures. Notice provided to the Participant will be deemed notice to all Dependents, unless the Fund has notice that your Dependent resides at a different address.

2. An Employer may notify the Fund if you lose coverage due to reduction in hours, termination of employment or death (but you or your covered Dependent should also call the Benefit Office to report these events).

3. You or your covered Dependent is responsible for notifying the Fund and providing documentation within 60 days of divorce, legal separation or a dependent no longer being eligible for coverage, or if you become eligible for, entitled to or enroll in Medicare. If you don't notify the Fund within 60

days of a qualifying event, your Dependent will lose eligibility for continuation coverage under COBRA.

4. Once you or your Employer notifies the Fund of a qualifying event, the Fund will send you a COBRA notice and enrollment form within 14 days.

5. You have a 60-day election period to complete and return the enrollment form to the Benefits Office. If you don't return the form within 60 days, you lose eligibility for continuation coverage under COBRA.

6. You may elect coverage for yourself and/or your eligible Dependents. If you decline coverage for yourself, your eligible Dependents may elect coverage independently from you.

7. Any qualified beneficiary who elects continuation coverage under COBRA must notify the Benefit Office within 14 days of becoming covered under another group health plan.

8. A qualified beneficiary may elect continuation coverage for his Dependents. However, each qualified beneficiary has an independent right to elect continuation coverage under COBRA.

Paying for Continuation Coverage under COBRA

The Benefit Office will notify you of the cost of continuation coverage under COBRA when it notifies you of your right to continue coverage. The cost for continuation coverage under COBRA will be determined by the Trustees on an annual basis, and will not exceed 102% of the cost to provide that coverage. The cost for extended continuation coverage under COBRA if you are disabled (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your first Premium payment for continuation coverage under COBRA must include payments for any months retroactive to the day your coverage under the Plan ended. This Premium payment is due no later than 45 days after the date you signed the election form and returned it to the Benefit Office.

Subsequent Premium payments are due on the first business day of each month for which coverage is provided (due date). There is a grace period from the due date of the Premium payment by which time the Premium payment must be paid. Coverage will be provided as long as payment for that month is received by the Benefit Office with a postmark date no later than 30 days after the due date or, for months with 31 days, the last day of the month in which the Premium payment is due.

However, if a monthly payment is paid later than the first day of the month, but before the end of the grace period, coverage will be suspended as of the first day of the monthly coverage period. Upon receipt by the Benefit Office of the monthly Premium payment, coverage will be retroactively reinstated going back to the first day of the month. Any claim submitted for benefits while coverage is suspended will be denied by the Plan and must be resubmitted for payment once coverage is reinstated.

If payment is not received within the grace period, all benefits will end immediately. Once your continuation coverage under COBRA is terminated, it cannot be reinstated.

Electronic Payments

You can set up online payment for paying Premium payments for continuation coverage under COBRA. An additional convenience service fee will apply for checking, savings and credit card transactions. **You cannot set up a recurring monthly payment through the electronic system. Payment must be made each and every month.**

You must first create an electronic payment account through the Benefit Office. To do so, you must return your application for continuation coverage with the first month's Premium payment via check or money order. **For qualified COBRA beneficiaries who individually elect "single" COBRA coverage in lieu of "family" coverage, you must make a separate Premium payment each month for each individual who elected "single" coverage.**

Once you have established your account, you can follow the instructions on the Fund's website at laborfunds.org to enter your COBRA ID number and access the electronic system.

To assist the Benefit Office in processing your Premium payment, you must specify the month(s) you are paying for in the applicable section on the website. You will receive a confirmation number once you have made your Premium payment. Look for your confirmation email. Save this email for your records.

Regardless of your payment method, failure to timely submit your Premium payment will result in cancellation of coverage.

Termination of Continuation Coverage under COBRA

The Fund will automatically terminate continuation coverage under COBRA in all instances permitted by the COBRA statute and its regulations, including if:

- You do not make timely Premium payments under the Plan;
- You become covered under another health care plan that does not exclude coverage for pre-existing conditions that are covered by this Plan;
- You become entitled to, eligible for and enrolled in Medicare coverage; or
- The Trustees discontinue all coverage under the Plan.

It is the intent of the Trustees to provide continuation coverage under COBRA benefits in accordance with the federally required minimum benefits provisions of COBRA. The Fund has developed administrative guidelines and interpretive procedures to be used in complying with the continuation of benefits provisions of COBRA. To the extent that this or any administrative guidelines or interpretive procedures inadvertently conflict with COBRA, the applicable sections of COBRA will prevail.

G. CONTINUATION OF GROUP HEALTH COVERAGE UNDER USERRA

Your benefits under the Plan end when you are deployed; however, when you return you are eligible for continuation of coverage. Upon returning from the Military Service, you may be able to continue

health coverage (medical, prescription drug, dental and vision benefits, as applicable) under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

Continuation coverage under USERRA will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your regular Plan coverage ends.

To continue coverage, you must elect continuation coverage under COBRA and pay for it, as described on pages 21-22. If you go into active Military Service for less than 31 days, your coverage will be continued at the rate you were paying for coverage prior to your military leave.

However, in the event of a conflict between the provisions of continuation coverage under USERRA and COBRA, if you are eligible to continue coverage under both provisions, you will be entitled to the more generous coverage provisions of USERRA or COBRA. Continuation coverage under USERRA and COBRA will run concurrently. The administrative procedures with regard to notice, election and payment for continuation coverage under COBRA apply to continuation coverage under USERRA.

When Continuation Coverage Under USERRA Ends

Continuation coverage under USERRA may end sooner than described above for any of the following reasons:

- You lose your rights under USERRA, such as for a dishonorable discharge;
- You fail to pay the Premium for continuation coverage under USERRA;
- The Plan ceases providing group health plan coverage; or
- You fail to return to work or apply for reemployment within the time required under USERRA.

In the event that health coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which the Premium is paid in whole or in part by an Employer, then the Premium you are required to pay may increase for the remainder of the period provided above.

H. FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- Birth, adoption or placement of a child with you for foster care or adoption;
- Care of a seriously ill spouse, parent or child;
- Your serious illness; or

- A qualifying urgent need to leave because your spouse, son, daughter or parent has been notified of an impending call or order to active duty in the U.S. armed services in support of a military operation.

During your leave, you will maintain all the coverage offered through the Fund, to the extent the Plan receives contributions from the Employer for time you spend on a leave under FMLA. You are eligible for a leave under FMLA if you:

- Have worked for a contributing Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within 75 miles.

The amount of monthly Employer contributions required to continue your current level of coverage while on a leave under FMLA will be determined using the average monthly hours you work during the 12-month period preceding the month in which you begin a leave under FMLA.

Certain Employees are also allowed to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member who is the son, daughter, parent, or next of kin of the employee. The service member must be undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the military, or is otherwise in outpatient status or on the temporary disability retired list of the armed services.

The Fund will maintain your prior eligibility status until the end of your leave under FMLA, provided the contributing employer properly grants the leave under federal law and the contributing Employer makes the required notification and payments to the Fund.

The Benefit Office requires satisfactory proof of your Employer's approval of your leave under FMLA. If you and your contributing Employer have a dispute regarding your eligibility and coverage under FMLA, the Fund will have no direct role in resolving such dispute, and your benefits may be suspended pending resolution of the dispute.

COMPREHENSIVE MEDICAL BENEFITS

The Plan's Medical Benefit provides benefits for a wide range of health care services and supplies used to diagnose and treat non-occupational 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.

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 Carpenters Wellness Centers.

A. MEDICAL NETWORKS

The Plan enters into contracts with medical Network Sponsors to allow 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 below.

If you choose an In-Network Provider, the Plan's benefits covered are higher than if you choose a Non-Network Provider. 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.

The Plan's Networks at the date of this SPD, for purposes of medical care are as follows:

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).

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.

Member Assistance Program

The Member Assistance Program (MAP) provides mental health and substance abuse treatment services through the Fund's Contracted provider, Mercy Managed Behavioral Health (Mercy). You also have access to online resources and information for personal and work-life issues.

The Plan maintains updated information about the Mercy MAP, Networks and In-Network Providers at the Benefit Office and on the Plan's website, laborfunds.org.

B. DETERMINATION OF BENEFIT AMOUNTS

Allowable Amount

Upon receiving a claim, and after confirming the claimant is a Covered Person and the claim is for a Covered Expense, the Plan determines the Allowable Amount. 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.

Reasonable and Customary Amount

The reasonable and customary amount for Covered Expenses covered by Medicare is equal to 100% of the Medicare approved amount. For Covered Expenses 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.

Deductibles

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 Individual Deductible is embedded within the Family Deductible.

The Deductible does not apply to a benefit for which a Copayment is required or the prescription drug, dental or vision benefits .

The In-Network and Out-of-Network Deductibles are separate Deductibles and are not combined to reach maximums. Covered Expenses for Protected Services and Continuing Care Services are applied to the In-Network Deductible.

Copayments

A Copayment is a fixed dollar amount that must be paid by a Covered Person towards an Allowable Amount 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.

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%.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum applies to each Covered Person. 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. In-Network and Out-of-Network out-of-pocket expenses are separate and cannot be combined to reach the Out-of-Pocket Maximums. Cost-sharing amounts that a Covered Person pays for Protected Services and Continuing Care Services count only toward the In-Network Out-of-Pocket Maximum.

The following expenses are not applied to the Out-of-Pocket Maximums:

1. Charges for services and supplies not covered by the Plan.

2. Charges from a Non-Network Provider in excess of the Plan's Allowable Amount.

3. Charges from a Non-Network Provider for which no Plan benefits are paid because of failure to obtain required Prior Authorizations.

4. Charges exceeding Plan benefits for services and supplies within the Prescription Drug Benefit, the Dental Benefit, or the Vision Benefit.

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.

Benefits Payable

The benefits payable by the Plan for a Covered Expense is the Allowable Amount, less any applicable Copayment, 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.

C. PRIOR AUTHORIZATION REQUIREMENTS

The Plan specifies certain services and supplies for which Prior Authorization is required as a condition of receiving such 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.

1. Abortion, which means the termination of Pregnancy before the fetus reaches the stage of viability.
2. Non-Emergent Ambulance service by air and water, or transfers between facilities
3. Breast pumps, Hospital grade
4. Chemotherapy and Radiation Therapy
5. Clinical Trials
6. Dental Services (when covered under Medical Benefit)
7. Dialysis
8. Durable Medical Equipment for rentals over $500; purchases over $750 ($1,000 for prosthetics.)
9. Genetic Testing and Counseling
10. Home Health Care Services
11. Hyperbaric treatment
12. Inpatient Hospital Care, except maternity admission to a Hospital not exceeding 48 hours following a vaginal delivery or 96 hours following a Cesarean section
13. Inpatient, Residential, Intensive Outpatient and Partial Hospitalization Mental and Nervous Disorders and Substance Abuse
14. Outpatient surgeries not performed in a physician's office including cosmetic, plastic and related reconstructive surgeries Pain Management Injections
15. PKU or other Amino and Organic Acid Inherited Disease Formula and Food
16. CT scans, MRIs, MRAs, PET scans, nuclear cardiology
17. Sclerotherapy
18. Sleep Studies
19. Skilled Nursing Facilities
20. TMJ treatment – surgical or non-surgical

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

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. 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.

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.

D. 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.

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.

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.

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:

1. Early intervention and appropriate care.
2. Coaching to support behavior change.
3. Shared decision-making.
4. Pre- and post-surgical counseling.
5. Support in choosing treatment options.
6. Education on back-related information and self-care strategies.
7. Long-term support.
8. 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.

E. PROTECTIONS FROM SURPRISE MEDICAL BILLS

The No Surprises Act includes rules to protect you from surprise balance billing. Surprise balance bills are what Out-of-Network Providers can charge you after you pay your Deductible, Copayment, or Coinsurance – also known as your "cost-sharing" amounts. Under these rules, Out-of-Network Providers can no longer send you these surprise balance bills in the following situations:

- Emergency Services (not including ground ambulance services) from an Out-of-Network provider, facility, or air ambulance. This includes services you receive after you are in stable condition unless you give written consent.
- When you receive certain Protected Services, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon services, hospitalist services, or intensivist services, from an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center.

Where balance billing is not allowed:

- You will pay only In-Network cost-sharing amounts.

- Your cost-sharing amounts will be based on what the Fund would pay for the services had they been provided by an In-Network provider.

- What you pay will count toward your In-Network deductible and out-of-pocket limit.

- If a claim is denied for a service protected from balance billing, you can submit the claim for external review at the end of the appeal process.

Out-of-network providers can ask you to give up your balance billing protections for post-stabilization services and other services you may receive from an out-of-network provider at an in-network hospital or ambulatory surgical center.

Don't accidentally give up your protections against balance billing!

Read any consents you are given before you receive health care.

In addition to the balance billing protection, the No Surprises Act also provides you the following protections:

- If an In-Network Provider leaves the UMR Network, you may be able (upon review by UMR) to receive care as if the Provider was still an In-Network Provider for up to 90 days so that you have time to transition to an In-Network Provider. You will have this option if you are inpatient, scheduled for nonelective surgery, or receiving care for a pregnancy, serious and complex condition, or terminal illness when your Provider leaves the UMR Network.

- If you can show that you received inaccurate information from UMR that a Provider was an In-Network Provider, then you will pay In-Network cost-sharing for that claim. However, note that the Out-of-Network provider may still balance bill you for that claim.

F. COVERED SERVICES AND EXCLUSIONS

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 Medically Necessary, not otherwise excluded by the Plan, and are performed or ordered by a Provider.

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 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 Great distances, limited time frames, or other obstacles to land transport would prevent getting the patient to the nearest Hospital with appropriate facilities for treatment.	Prior Authorization is required for non-emergent transportation from one Hospital or medical facility to another. **Limitations:** Emergency air or water transport is covered only for the lowest cost aircraft or vessel available and appropriate for the patient's medical condition. **Exclusions:** All ambulance transportation services are excluded if the required criteria are not met, including, transportation that is primarily for repatriation (e.g., to return the patient to the United States)
Anesthesia	Anesthesia administered by a Physician or qualified Allied Health Professional.	**Exclusions:** Anesthesia in conjunction with non-covered medical or surgical procedures.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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.
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.
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.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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. • 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.	**Limitations:** 60 visits per calendar year.
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.	

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Clinical Trials	Routine patient care incurred as a result of enrollment in Phase I, II, III or IV clinical trials undertaken for the purposes of the prevention, early detection, or treatment of cancer, if the clinical trial is conducted at an academic or NCI center and is approved or funded by one the following entities: 1. National Institute of Health (NIH). 2. An NIH cooperative group or center. 3. The FDA in the form of an investigational new drug application. 4. The federal Departments of Veterans' Affairs or Defense. 5. A qualified research entity that meets the criteria for NIH Center support grant eligibility. An institutional review board that has an appropriate assurance approved by the Department of Health and Human Services.	Prior Authorization required. **Exclusions:** Patient care for any clinical trial that does not meet the stated criteria; any non-health care services required in conjunction with the clinical trial (such as transportation, lodging, Custodial Care); services and supplies provided to enrollees in the clinical trial without charge; services required to conduct, manage and administer the clinical trial or to collect and analyze data; and supplies and services that would not be covered for reasons other than being Experimental or Investigative. Listed service or supply if required Prior Authorization was not obtained.
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 under the Plan's criteria for breast reconstruction following a covered mastectomy. Also see Reconstructive Surgery.	Prior Authorization required. **Exclusions:** Services or supplies that are not obtained as soon as medically appropriate. Except as expressly listed, cosmetic or reconstructive procedures and any related services or supplies which alter appearance but do not restore or improve impaired physical function. Listed service or supply if Prior Authorization was not obtained.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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.
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.	

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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.
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.
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 Physician services in a Provider's office, when traveling outside the United State,	**Exclusions:** No benefits are payable for non-Emergency services received in an Emergency Room.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Eye Refractions	Covered if related to a covered medical condition	
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. 4. A treatment plan has been established and periodically reviewed by the ordering Physician. 5. Services were approved in the Plan's Prior Authorization procedures. 6. The agency rendering services is Medicare certified and licensed by the State of location. 7. The patient is homebound or confined in a custodial setting.	Prior Authorization required. **Limitations:** Home Health visits are limited to 100 visits per calendar year. A visit is defined as four or less hours. **Exclusions:** Listed service or supply if Prior Authorization was not obtained.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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 physical or occupational therapist or nutrition counseling services provided by or under the supervision of a 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 social worker, pastoral counselor, psychologist, psychiatrist, or other Provider, if applicable. The services must be furnished within six months of death.	
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**.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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.
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.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Maternity and Pregnancy Services	Maternity-related medical, Hospital and other covered services and supplies for the mother and her newborn Child, including up to 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 visits, at least one 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 midwives 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 except in Emergency.
Medical Complications	Complications arising from a covered surgical procedure.	**Exclusions:** Complications following a covered surgical procedure 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 visits per episode. **Exclusions:** MAP services are available only through the Mercy Member Assistance Program which is a part of the Mercy Managed Behavioral Health Network. To obtain services through the MAP call 314-729-4600 or toll-free at 800-413-8008.
Mental Health and Substance Abuse Services (MHSA)	Services and supplies for diagnosis and treatment of mental health and substance abuse conditions are covered. **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.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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 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.
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.

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 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.	

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. **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)
Preventive Services	The Plan covers Preventive services regardless of Medical Necessity in accordance with the ACA Preventive Care Recommendations. Plan covers all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. The following contraceptives will be processed under the medical benefit:	**Limitations:** Breast pumps are limited to the lesser of cost of purchase or rental of one pump per pregnancy in conjunction with childbirth.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
	• Contraceptive injections (such a Depo-Provera) and their administration regardless of purpose. • Contraceptive devices such as UIDs and implants, including their insertion and removal regardless of purpose.	
Prosthetic Devices	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 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.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Reconstructive Surgery	Following a Medically Necessary mastectomy, 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, aesthetic flat closure, internal or external prosthesis, and lymphedema. Also see Cosmetic, Plastic and Related Reconstructive Surgery	**Exclusions:** Reduction or augmentation mammoplasties that are not Medically Necessary and are unrelated to a Medically Necessary mastectomy.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Rehabilitation Services and Supplies Visits	Therapy prescribed by attending Physician, and provided in an outpatient setting by a Provider within the scope of their respective licenses, includes: • **Occupational therapy** by an occupational therapist (OT) or other appropriately licensed Provider, if applicable. • **Physical therapy** by a physical therapist (PT) or other appropriately licensed Provider, if applicable. • **Respiratory therapy** by a respiratory therapist (RT) or other appropriately licensed Provider, if applicable. • **Aquatic therapy** by a physical therapist (PT), aquatic therapist (AT), or other appropriately licensed 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 speech therapist (ST) or other appropriately licensed 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 an appropriately licensed 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. 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	**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.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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 Skilled Nursing Facility (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.
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.

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Temporomandibular Joint Disorder 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.
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 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.	
Virtual Office Visits	Virtual office visits, or telehealth, with a Physician are covered. Telemedicine services are covered through Teladoc.	

SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
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.	

G. GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

Irrespective of all other provisions, no medical benefits will be paid for or in connection with services listed as an excluded service in Section F above or the following excluded services:

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 an 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 Allowed 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 routine care costs associated with qualifying clinical trials.

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 hormones.

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 a Covered Person's 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 except in the event of an Emergency.

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.

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:

    (a) Medications that, due to their characteristics (as determined by the Plan), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

    (b) 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 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, except as specifically covered.

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

WELLNESS CENTER

A. OVERVIEW

The Carpenters Wellness Center offers a range of primary and urgent care services for you and your eligible Dependents (age two and older), provided you meet the Plan's eligibility requirements. There are two Wellness Centers:

1. Carpenters Wellness Center – St. Louis
   1403 Hampton Ave, St. Louis, MO 63139
   Updated services and hours of operation are located on the Plan's website:
   laborfunds.org/wellnesscenterstl

2. Carpenters Wellness Center – Kansas City
   8965 E 38th Terr, Kansas City, MO 64129
   Updated services and hours of operation are located on the Plan's website:
   laborfunds.org/wellnesscenterkc

Services for both locations are outlined in the following subsections.

B. ELIGIBILITY FOR SERVICES

All Covered Persons enrolled in either the Active Classification or Non-Active Classification are eligible for services at the Wellness Centers except as follows:

1. Dependents younger than the age of two are not eligible for any Wellness Center services;

2. Medicare-eligible Retirees and their eligible Dependents enrolled in the Medicare Advantage Program are eligible only for the pharmacy and vision services and, if elected, dental services;

3. Dependents are not eligible for hearing aid devices.

C. CARPENTERS WELLNESS CENTER – ST. LOUIS

Available Services in St. Louis

Carpenters Wellness Center services vary by location. Services available at the St. Louis Wellness Center include but are not limited to:

- Primary care services
- Annual school and sports physicals
- Acute care and sick care visits
- Audiology Services, including hearing exams, hearing aids and custom moldings
- 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

D. CARPENTERS WELLNESS CENTER – KANSAS CITY

Available Services in Kansas City

Services available at the Kansas City Wellness Center include but are not limited to:

- Primary care services
- Annual school and sports physicals
- Acute care and sick care visits
- Chiropractic care
- Holistic pain management
- Lab services
- Mental health and substance abuse counseling
- Patient education
- Provider dispensing pharmacy
- Preventive care
- Vaccinations and immunizations

- Wellness training
- X-ray

E. DEDUCTIBLE, COINSURANCE AND COPAYMENTS

Services through the Wellness Center are generally provided at no cost to eligible Covered Persons. Any applicable copayments are described in the Schedule of Benefits.

Covered Persons who are more than 10 minutes late or miss a scheduled appointment at the St. Louis Wellness Center 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.

PRESCRIPTION DRUGS

A. LEVELS OF BENEFIT

Prescription drugs can play an important role in your overall health. Recognizing this importance, the Plan provides comprehensive prescription drug coverage that is designed to help you pay for the medications you need. 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.

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.

Benefits for prescription drugs depend on whether the prescription is for a generic or brand name, and whether the medication is on the Plan's formulary. 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

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

Prescribed by a Physician; and

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

2. FDA approved for the condition for which prescribed; and

3. Medically Necessary, except for Preventive drugs; and

4. 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. Approval of a compound drug applies only to ingredients as submitted. Notwithstanding the forgoing, compound medications that have a commercially available non-compound alternative are not covered.

In addition, when legally supplied and administered by any licensed pharmacy, Preventive immunizations are also covered under the Prescription Drug Benefit.

Retail Pharmacy

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.

Mail Order

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 through the Network Sponsor's mail order program, 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.

Specialty Drugs

Drugs classified by the FDA as specialty drugs are covered only when obtained from the Network Sponsor's 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.

The Plan adopts and incorporates by reference the criteria of the Network Sponsor's 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.

Express Scripts is the Network Sponsor for the retail Network and Home Delivery Network. The specialty drug Network is known as **Accredo Specialty Pharmacy**.

C. SPECIAL COVERAGE LIMITATIONS

Prior Authorization

Prior authorization is required for certain drugs or quantities as a condition of receiving any prescription drug benefit. Prior Authorization is satisfied only if certified by the Network Sponsor. In-Network Providers are responsible for obtaining any required Prior Authorization for drugs they dispense. 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. 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 and the drug is determined to be Medically Necessary upon retrospective review.

Step Therapy Programs

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 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.

Second-line drugs are not covered unless the patient has first tried a prescribed course of first-line drugs 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.

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.

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. U.S. Food & Drug Administration (FDA) guidelines recommend the maximum quantities of these drugs that are proven safe and effective.

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.

D. NETWORK PROVIDERS

Except in an Emergency, the Plan pays prescription drug benefits only for drugs obtained from an In-Network Provider. All specialty prescriptions must be filled by the Network Sponsor's Specialty Network to be covered, except a specialty drug that is a limited distribution drug may be obtained from the approved issuing 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 in an Emergency when an In-Network Provider is not reasonably accessible as determined by the Trustees.

E. AMOUNT OF BENEFIT

No Deductibles are applicable. Copayments count toward the Out-of-Pocket Maximum.

The Allowable Amount for a drug is the lesser of the amount charged or the uniform charge that the Provider has agreed to accept as a member of the Network. 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. 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 minimum Copay shown in the Schedule of Benefits, the Covered Person is required to pay only the maximum Copay amount, and the Plan will pay the balance of the Allowable Amount.

Specialty Pharmacy Copay Assistance Program

Covered Persons who use Select Specialty Medications are required to participate in the Specialty Pharmacy Copay Assistance Program administered by the Plan's Contracted Provider, **SaveonSP**. When Covered Persons enroll in the SaveOnSP program there is no Copay for the Select Specialty Medication. If the Covered Person does not enroll in the program, the Covered Person is responsible for the full cost of the Select Specialty Medication and the costs are not applied toward satisfying the Deductible or the Out-of-Pocket Maximum. SaveonSP determines and identifies the Select Specialty Medications that are a part of the Specialty Pharmacy Copay Assistance Program.

F. 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.

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.

G. 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, including but not limited to GLP-1s (GLP-1 for treatment of diabetes are covered subject to prior authorization).

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.

DENTAL

Good health goes hand in hand with good dental care, which is why the Plan includes comprehensive dental care. This includes preventive dental care, such as routine exams, cleanings and X-rays; as well as basic dental care, major dental care and orthodontia for you and your covered Dependents.

The Dental Benefit is self-funded by the Plan. Premium Plan Dental is a comprehensive dental benefit. The Basic Plan Dental provides preventive services only.

The Plan has contracted with **Delta Dental, LLP**, to process dental claims, to make Prior Authorization determinations, and for access to the Dental Network. Covered Persons have access to:

1. The Delta Dental PPO Network and/or

2. 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.

Dental Benefits are characterized as an Excepted Benefit for all purposes but the Plan voluntarily complies with certain group health plan requirements as specifically set forth herein.

A. ELIGIBILITY

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

1. **Active Classification:** The Premium Plan's Dental Benefit is provided automatically, without additional contributions, to Participants in the Active Classification and their Dependents.

2. **Non-Active Classification:**

   (a) The Premium Plan's Dental Benefit is available as optional coverage, at an additional Premium, to Participants and Dependents in the Non-Active Classification including Participants and their Dependents enrolled in the Medicare Advantage Program.

   (b) 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 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.

3. For certain **Apprentice** eligibility classes, the Basic Plan Dental is provided to Participants and Dependents. Once the Apprentice becomes eligible for the Premium Plan, generally after a 30-

month waiting period, the Participant transfers from the Basic Dental Plan to the Premium Dental Plan.

B. 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 Network Provider. The deductible paid for preventive services counts toward the deductible for non-preventive 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 $2,000 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 $4,000. 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.

There is no Out-of-Pocket Maximum applicable to the Dental Benefit.

C. 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 contracted rate for the same procedure.

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.

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.

D. 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.

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 Network Sponsor.

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 the Network Sponsor before services are performed.

E. 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 Network Sponsor; 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

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
	• 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.
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, including 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.

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
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
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.

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

CDT CODE	DESCRIPTION
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. 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.

F. 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 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).

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 Person'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.

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.

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, except for Dependent Children 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).

All Coordination of Benefit Rules, definitions, filing limits and other limitations applicable to the medical plan are also applicable to the dental plan.

G. 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. "Dentist" means a dentist duly licensed and legally qualified to practice dentistry at the time and place covered dental services are performed.

VISION

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. 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.

Covered Persons are free to choose to obtain covered services and supplies from In-Network Providers or from Non-Network Providers. In general, Plan benefits are higher for In-Network Providers than for Non-Network Providers. In-Network vision Providers are named and updated on the VSP website at www.vsp.com.

Vision Benefits are characterized as an Excepted Benefit for all purposes but the Plan voluntarily complies with certain group health plan requirements as set forth below.

A. ELIGIBILITY

1. **Active Classification** - The Premium Vision Benefit Plan is provided automatically, without additional contributions, to Participants in the Active Classification and their Dependents.

2. **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.

3. **For certain Apprentice eligibility classes**, the Basic Vision Plan is provided to Participants and Dependents in lieu of the Premium Vision Benefit Plan. The Basic Vision Plan only provides access to the VSP networks and discounts; it does not provide benefits for the vision services and supplies listed below. Participants in the Basic Vision Plan must pay for services at 100%.

B. COVERED VISION SERVICES AND SUPPLIES

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 below; and

3. Are not excluded.

Covered Services and Supplies

1. Routine eye exam, one every 12 months.

2. Frames, one every 24 months.

3. Lenses, including lens enhancements, once every 12 months.

4. Contact lenses, covered in lieu of glasses, once every 12 months.

5. ProTec safety glasses, one every 24 months, In-Network only.

Conditions and Limitations

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

2. 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.

3. Lenses and frames obtained from a Network 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.

4. 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.

5. Contact lenses obtained from a Network Provider 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.

6. Contacts will be considered Medically Necessary only in one or more of the following situations, and only if pre-authorized by the Network Sponsor:

- Following cataract surgery; or
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses; or
- With Anisometropia (unequal refraction in the eyes); or
- 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. Requests for Prior Authorization must be submitted VSP. A Covered Person is responsible for ensuring that required Prior Authorization is obtained for services of a Non-Network Provider.

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 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 Network Provider's professional fees for contact lens evaluations and fittings not covered under this Plan. Discounts are applied to the Network Provider's usual and customary fees for such services and are available from a 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.

C. 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.

If a Covered Person elects to obtain non-standard frames or lenses from a Network 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 frames and lenses:

- Optional cosmetic processes; or
- Anti-reflective, color, mirror, or scratch coating; or
- Blended, cosmetic, laminated, oversized and progressive multifocal lenses; or
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2; or
- UV (ultraviolet) protected lenses.

D. 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 limits noted 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 Person 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.

E. SPECIAL LOW VISION BENEFIT

Independent of, and in addition to, the benefits described above, the Plan offers a special low vision benefit program through VSP. If an eye examination 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 the 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, 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 Non-Network 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.

SHORT-TERM DISABILITY BENEFITS

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

A. ELIGIBILITY

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

If an eligible Participant 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 the Participant's regular occupation. In addition:

1. 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.

2. The treating Physician must notify the Plan of any changes to the expected return to work date.

3. The Provider must provide 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.

B. BENEFITS PAYABLE

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

BENEFIT	AMOUNT
Short-Term Disability (Weekly Indemnity)	$550 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.

C. EXCLUSIONS

No benefits are payable for the following:

1. 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.

2. 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.

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

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

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

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

7. For Non-Bargained Office Employees, any Participant while covered under COBRA, or any Participant covered under the Non-Active Classification.

D. MATERNITY LEAVE BENEFIT

Pregnant Participants in the Active Classification are eligible for Maternity Leave Benefits, but excluding Non-Bargained Office Employees and Non-Bargained In-House Employees.

The Participant will receive a weekly payment and will be credited with up to forty (40) Contribution hours to this Plan for each calendar week of Physician certified pregnancy or pregnancy-related condition up to a maximum of twenty-six (26) weeks relating to the same pregnancy.

Benefits are available for no more than twenty-six (26) consecutive weeks, beginning no earlier than twenty-six (26) weeks before the expected due date, except for early delivery. The Fund must receive the required application forms completed in full by the Participant and the Participant's attending Physician prior to the commencement of benefits.

Maternity Leave Benefits are in lieu of Short Term Disability Benefits described in sections A-C above. A Participant receiving Maternity Leave Benefits is not eligible to receive Short Term Disability Benefits for the same pregnancy.

The Plan will follow Federal and State tax withholding rules when paying a Participant's weekly payment.

LIFE INSURANCE AND AD&D BENEFITS

The Plan provides Life and Accidental Death and Dismemberment (AD&D) benefits under policies insured by a commercial insurance company, Metropolitan Life Insurance Company (MetLife). 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.

A. ELIGIBILITY

1. **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.

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

3. For **Apprentice** eligibility classes, the life insurance benefit is part of the benefits offered to them in the Basic Plan

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

B. BENEFITS PAYABLE

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

LIFE INSURANCE BENEFITS	
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

ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS	
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 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 Schedule of Benefits 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.

C. DESIGNATED 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. In the event of divorce, a beneficiary designation naming the Participant's former spouse as beneficiary (but not other beneficiary designations) will be canceled as of the date of divorce, unless the Plan receives a qualified domestic relations order naming the former spouse as the Participant's beneficiary for life insurance purposes or the Participant re-designates the former spouse as beneficiary following divorce.

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:

To the Participant's Surviving Spouse.

1. If there is no Surviving Spouse, to the Participant's surviving child or children, equally.
2. If there are no surviving children, to the Participant's surviving parents, equally.
3. If there are no surviving parents, to the Participant's siblings, equally.
4. 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.

D. 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:

1. Remains continuously Totally Disabled,

2. Submits written proof of the uninterrupted continuance of Total Disability to the insurance company as follows:

   (a) 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.

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

3. Submits to medical examination by a Physician selected by the insurance company whenever required by the insurance company,

4. Does not establish a claim under the conversion privilege, and

5. 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.

E. 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.

F. LIMITATIONS ON AD&D BENEFITS

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

1. Physical Illness, diagnosis, or treatment for the Illness; or
2. An infection, unless it is caused:
3. by an external or internal wound which was sustained in an accident; or
4. by the accidental ingestion of a poisonous food or substance; or
5. Suicide or attempted suicide while sane; or
6. Injuring oneself on purpose; or
7. The use of any drug or medicine unless taken on advice of and consistently with the instructions of a doctor; or
8. A war or war-like action in time of peace, including terrorist acts; or
9. 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.

G. EXCLUSIONS

No benefits are payable under this section:

1. For any Participant while covered under COBRA.
2. For any Participant or Dependent covered under Section I.A.3 as a Non-Bargained Office Employee.
3. Dependents in the following categories:
   (a) An individual who did not live in the United States or Canada at the time of death.
   (b) A stillborn or unborn child.
   (c) An individual in whom the insurance company determines the related Participant had no insurable interest.
   (d) A Participant's Dependent in the Non-Bargained Office Employee group.
   (e) A Dependent with COBRA continuation coverage.

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

4. For any Participant or Dependent enrolled in the Medicare Advantage Program.

SAFETY ENHANCEMENT BENEFITS

A. ELIGIBILITY

The following individuals are eligible for safety enhancement benefits:

1. Bargained Employees

2. 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 the Plan.

B. 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 Hours of Approved Safety Training per year to satisfy requirements of the Union.

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.

C. SUBSTANCE ABUSE TESTING

The Plan will provide without charge, to all persons eligible for the safety enhancement benefit, 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.

CLAIMS AND APPEALS

This section describes the procedures for filing claims for benefits from the Plan. It also describes the procedures for you to follow if your claim is denied, in whole or in part, and you wish to appeal the decision.

A. REQUIRED FORMS

When you are first eligible for benefits and thereafter on an annual basis or upon request, you must complete certain required forms that validate census data including information about your spouse, Dependent child(ren), and other insurance coverage. Coverage will not be effective for Dependents until the required forms are fully completed and accepted by the Benefit Office.

You must update information on file with the Benefit Office by notifying the Benefit Office as soon as possible of any change. Coverage may be delayed or suspended if the update or the required forms are not received in a timely manner.

B. GENERAL RULES GOVERNING CLAIMS

Claims must be submitted to the Plan's Provider of service. If a Covered Person's provider and service(s) were obtained outside the Contracted Provider's Network area, the provider must file the Claim with the Contracted Provider or the local affiliate of the Contracted Provider, if applicable.

Each Claim must include:

- Patient name and date of birth;
- The Participant's name and Social Security number or other ID number assigned by the Fund;
- Date of service or date of fill or refill for prescription drug Claims;
- Specific services performed and expenses charged for each service;
- Diagnosis and type of service defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges for each service;
- Attending Physician's or care provider's name and federal tax ID number (not required for prescription drug Claims);
- Place of service;
- Billing address; and
- Previous balances paid.

A Covered Person must pay any amounts not paid by the Fund, with the exception of Network discounts or discounts that may be negotiated between the Plan and the provider on Out-of-Network Claims. Network or other negotiated discounts do not apply to expenses that are not covered by the Plan.

A Covered Person is prohibited from assigning his rights under the medical portion of the Plan to a third party or in any way alienating the Covered Person's Claims for benefits. Any attempt to assign rights or in any way alienate a Claim for benefits will be void and will not be recognized by the Fund as an assignment.

The Fund will treat any document attempting to assign your rights, or to alienate a Claim for benefits to a provider, as an authorization for direct payment by the Fund to the provider. In the event that the Fund receives a document claiming to be an assignment of benefits, the Fund may send payments for the Claims to the provider, but will send all Claim documentation, such as an explanation of benefits, and any procedures for appealing a Claim denial directly to the Covered Person. If the Fund denies the Claim, only you, your spouse, the patient or his Authorized Representative will have the right to appeal.

The Fund will pay Claims only when covered under the terms of the Plan provisions under which a Covered Person is eligible. If the Fund pays claims that it is not required to pay, it may recover and collect payments from a Covered Person or any other entity or organization to whom the Fund was not required to make the payment or that received an erroneous payment. The Fund may recover such erroneous payments through, but not limited to, an offset or reduction of any future benefits a Covered Person, or other eligible Dependent(s), may be entitled to receive from the Fund. The Fund shall be permitted to pursue legal and equitable remedies to recover overpayments.

For the purposes of this section, the Claims Fiduciary means the entity that has full discretionary authority to interpret the terms of the Plan and to decide benefit claims under the Plan and the appeal of such decision, and to maintain any applicable external review process. The Plan's Claims Fiduciary is the Board of Trustees unless the Trustees take action to delegate such authority to a third party Claims Fiduciary, such as to an insurance carrier or to a third party service provider responsible for maintaining a benefit program under the Plan.

Please note that the Trustees have designated Claims Fiduciaries for the Plan who have the authority to decide and review all benefit claims and all denied claims upon appeal under the Plan as follows:

- **Benefit Office** for enrollment, eligibility, Premium payments, Short Term Disability Claims, and Safety Enhancement Benefit Claims.
- **UMR** for medical Claims.
- **Delta Dental of Missouri** for dental Claims.
- **Express Scripts, Inc.** for prescription drug Claims.
- **Accredo Specialty Pharmacy** for specialty drug Claims.
- **VSP** for vision Claims.
- **Metropolitan Life Insurance Company** for life insurance and accidental death and dismemberment Claims.

The above Claims Fiduciaries are named fiduciaries under the Plan and have the authority to make final decisions regarding Claims for benefit consideration under the Plan.

C. AUTHORIZED PERSONAL REPRESENTATIVE

You may designate an Authorized Personal Representative to act on your behalf by notifying the Benefit Office and completing and submitting an Authorized Personal Representative Form or other form or procedure required by a designated third party Claims Fiduciary. Only the Authorized Personal Representative Form issued by the Fund or other form or procedure required by a designated third party Claims Fiduciary will be accepted. If an authorized personal representative is designated, correspondence relating to the claim or subsequent appeal may be shared with the designated authorized personal representative, unless otherwise specified. An individual who holds a health care power of attorney is deemed an authorized representative.

D. TYPES OF CLAIMS

There are three basic types of Claims under the Plan:

1. **Health Care Claims** include medical, prescription drug, dental, hearing, and vision Claims. Health Care Claims include the following:

   (a) **Pre-Service Health Care Claim**: any Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before the Covered Person obtains medical care;

   (b) **Urgent Health Care Claim**: any Claim for medical care or treatment with respect to which the application of the periods for making pre-service Claim determinations would, in the opinion of a Physician with knowledge of the Covered Person's condition, seriously jeopardize the Covered Person's life or health or ability to regain maximum function if normal pre-service standards were applied; or would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment for which approval is sought;

   (c) **Post Service Health Care Claim**: any Claim for health care benefits for which the Covered Person has already received the services in the Claim; and

   (d) **Concurrent Care Claim**: any Claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits, an extension of benefits, or a termination of benefits;

2. **Short Term Disability Claims.**

3. **Other Benefit Claims**, which include Life Insurance benefits and Accidental Death and Dismemberment benefits.

E. SUBMISSION OF CLAIMS

Claims may be submitted in the form specified by the designated Claims. A provider may submit a Claim on the Claimant's behalf. Claims recognized under the Plan include requests for:

1. **Medical benefits**, when accompanied by a Hospital, Physician, prescription, dental, hearing, or vision bill; or other type of invoice that includes the details specified on page 89;

2. **Short Term Disability benefits**, when accompanied by a Claim form completed by you and your attending Physician; or

3. **Life Insurance and/or Accidental Death and Dismemberment benefits**, when accompanied by an original certified death certificate and/or other required documentation as required by the Insurance Company or Benefit Office.

Incomplete Claims: If the Plan receives a document or transmission that contains, at a minimum, the following six items, it will be considered a Claim, even if additional information is required to process the Claim. If additional information is required, the Claimant will receive an extension for filing the Claim.

1. Patient name and date of birth;

2. Participant name and Social Security number or other ID number assigned by the Benefit Office;

3. Date of service or date of fill or refill for prescription drug Claims;

4. Specific services performed and itemized charges for each service;

5. Diagnosis and type of services as defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges for each service; or

6. Attending Physician's or care Provider's name and federal tax ID number (not required for prescription drug Claims).

Items not treated as Claims for benefits include any general inquiry about benefits or the circumstances under which benefits might be paid under Plan terms.

F. WHEN A CLAIM MUST BE FILED

A Claim for benefits must be filed with the designated Claims Fiduciary within the time periods listed below, or such other period as determined by the Claims Fiduciary:

1. **Medical Claims**: within 12 months from the date of service.

2. **Prescription Drug Claims**: within 12 months from the date of service.

3. **Dental Claims**: within 365 days from the date of service.

4. **Vision Claims**: within 365 days from the date of service.

5. **Short-Term Disability Claims**: within 365 days from the initial date of Disability.

6. **Life and Accidental Dismemberment Claims**: within 365 days after the date of the loss.

G. PROCESSING PROCEDURES FOR INITIAL CLAIMS

When a Claim is submitted for benefits, the Benefit Office or the designated third party Claims Fiduciary on behalf of the Trustees will determine if the Covered Person is eligible for benefits and will calculate the amount of any benefits payable.

The deadlines for processing the initial determination of a Claim vary by Claim type, as follows:

1. **Health Care Claims.**

   (a) Urgent Health Care Claims: within 72 hours of receipt of the Claim.

   (b) Pre-Service Health Care Claims: within 15 days of receipt of the Claim.

   (c) Post Service Health Care Claims: within 30 days of receipt of the Claim.

   (d) Concurrent Care Claims: as soon as possible and in time to receive a decision before reduction or termination of the benefit

2. **Short Term Disability Claims** will be determined within 45 days of receipt of the Claim

3. **Other Benefit Claims** (Life Insurance and Accidental Death and Dismemberment) will be determined within 90 days of receipt of the Claim.

Extension of the Initial Determination Period

In some instances, an extension of the initial determination period may be required due to matters beyond the Claims Fiduciary's control. The Claimant will be notified by the Claims Fiduciary if an extension is necessary. The Claims Fiduciary's notice will include the special circumstances requiring the extension and the date the Claims Fiduciary expects to render a decision, as follows:

1. **Urgent Health Care Claims:** The deadline for urgent health care claim cannot be extended.

2. **Pre-Service Health Care Claims:** The Claimant will be notified within the 15 day initial determination period that one 15 day extension is necessary.

3. **Post-Service Health Care Claims:** The Claimant will be notified within the 30 day initial determination period that one 15 day extension is necessary.

4. **Short Term Disability Claims:** The Claimant will be notified within the 45 day initial determination period that up to an additional 30 days maximum is necessary. If a determination is not made within the first 75 days, the Claimant will be notified that an additional 30 days is necessary.

5. **Other Benefit Claims:** The Claimant will be notified within the 90 day initial determination period that up to an additional 90 days may be necessary. The extension cannot be more than 90 days from the end of the initial 90 day period, or 180 days total.

Additional Information Required

The Claimant will be notified when additional information is needed to process a Claim, as follows:

1. **Health Care Claims:** Within the 15 day or 30 day initial determination period. The Claimant (or his provider, if his provider is notified) has up to 45 days to provide the requested information. If the Claims Fiduciary receives the requested information in the 45 day period, the Claim will be processed within 15 days following the receipt of the additional information. For an Urgent Care Claim, the deadline for additional information is as soon as possible but within 24 hours of the

receipt of the Claim. The Claims Fiduciary must notify the Claimant of the specific information needed and the Claimant has at least 48 hours to provide the information.

2. **Claims for Short Term Disability Benefits:** Within the 45 day initial determination period. The Claimant has up to 45 days to provide the requested information.

3. **Other Benefit Claims:** Within the 90 day initial determination period. The 90 day extension of the initial determination period listed above includes any time needed by the Claims Fiduciary to obtain this information.

Notice of Adverse Benefit Determination

If a Claim is denied, in whole or in part, the Claims Fiduciary will send the Claimant a written notice of the Adverse Benefit Determination that includes the following information:

1. **For Health Care Claims:**

   (a) The specific reason or reasons the Claim was denied in whole or in part;

   (b) Reference to the specific Plan provisions on which the denial was based;

   (c) A description of any additional information that a Covered Person will need to submit in support of his Claim and an explanation of why the additional information is needed;

   (d) An explanation of the Plan's Claim review procedures and applicable time limits;

   (e) Copy of any internal rule, guideline, protocol or similar criteria that was relied on, or the notice will include a statement that a copy is available at no cost upon request if relevant;

   (f) Copy of the scientific or clinical judgment, or the notice will include a statement that a copy of the scientific or clinical judgment is available to a Covered Person at no cost upon request, and

   (g) A statement of a Covered Person's rights under ERISA to bring a civil action and the applicable deadlines.

2. **For Health Care Claims except dental and vision:**

   (a) Information sufficient to identify the Claim including: date of service; provider; Claim amount; the denial codes and their respective meanings: a description of any standard used in determining the denial; a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge, and disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes.

   (b) Notice that the Claimant may request an external review with an independent review organization after the Plan's procedures have been exhausted.

3. **For Short Term Disability Claims:**

(a) The specific reason or reasons the Claim was denied including a discussion of the decision and, if applicable, an explanation of the basis for disagreeing with or not following:

(i) The views of a health care or vocational professional who treated or evaluated the Employee;

(ii) The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; or

(iii) A disability determination made by the Social Security Administration;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional information that an Employee will need to submit in support of his Claim and an explanation of why the additional information is needed;

(d) An explanation of the Plan's Claim review procedures and applicable time limits;

(e) Copies of any internal rule, guideline, protocol or similar criteria relied on, or a statement that no such rule, guideline, protocol or similar criteria exists;

(f) Copy of the scientific or clinical judgment, or the notice will include a statement that a copy of the scientific or clinical judgment is available to an Employee, or his Authorized Personal Representative, at no cost upon request;

(g) A statement that the Employee, or his Authorized Personal Representative, is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to his claim upon request, free of charge; and

(h) A statement of an Employee's rights under ERISA section 502(a) to bring a civil action and the applicable deadlines.

4. For Other Benefit Claims:

(a) The specific reason or reasons the Claim was denied;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional information that an Employee or an Employee's designated beneficiary will need to submit in support of his Claim and an explanation of why the additional information is needed;

(d) An explanation of the Plan's Claim review procedures and applicable time limits;

(e) A statement of the Employee's rights under ERISA Section 502(a) to bring a civil action and the applicable deadlines.

H. ADVERSE BENEFIT DETERMINATION APPEALS

1. Health Care Claims.

(a) An Adverse Benefit Determination is:

(i) A denial, reduction, or termination of, or failure to provide or make payment in whole or in part for a benefit; or

(ii) Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage, as described more fully on pages 134-135, is a cancellation or discontinuation of coverage that has a retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions in a timely manner, or other events (such as fraud).

(iii) An Explanation of Benefits (EOB) serves as the notice of an adverse benefit determination for a Health Care Claim.

(b) All appeals must be in writing, contain the signature of the Claimant on the forms required by the applicable Claims Fiduciary and addressed to the applicable Claims Fiduciary.

(i) A written appeal should include evidence or specific facts and Benefit Plan provisions that support a Claim for benefits. A Claimant should submit a completed Appeal Form and any additional information to substantiate the appeal to the applicable Claims Fiduciary.

(ii) An appeal must contain all of the information listed on page 89 as well as any denial codes corresponding meanings. An appeal for claims from an applicable third party Claims Fiduciary must contain all of the information required by the applicable Claims Fiduciary on the forms required by such Claims Fiduciary.

(c) Only a Claimant or his Authorized Personal Representative has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries for information on whether a certain medical procedure, prescription, Treatment Plan or other similar request is covered by the Plan is not considered a Claim for benefits.

(d) If a post-service Claim has been denied, in whole or in part, a Claimant has no more than 180 days after the receipt of an adverse benefit determination to file an appeal.

(e) Upon appeal, a Covered Person has the right to:

(i) Designate an Authorized Personal Representative (who may be an attorney);

(ii) Submit additional material, including comments, statements, or documents;

(iii) Be advised of the identity of any medical expert; and

(iv) Upon appeal of all health care claims except dental and vision, the Claimant also has the right to receive copies, free of charge, of all new or additional evidence considered, relied upon or generated by the Plan, or any new or additional rationale relied upon in connection

with the Claim. Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Claims Fiduciary's final decision in order to give the Claimant a reasonable opportunity to respond. If the new or additional evidence is received so late that the Claimant will not have a reasonable opportunity to respond within the prescribed time frame, the time period for the Claims Fiduciary to issue a decision will be tolled until the Claimant has an opportunity to respond. After the Claimant responds, or fails to respond, the Claims Fiduciary will issue its decision as soon as reasonably practicable.

(f) Notification of Decision on Appeal.

(i) Urgent Care Claims. The Claims Fiduciary shall notify the Claimant of the Plan's decision on appeal 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 request for review.

(ii) Pre-service Claims. The Claims Fiduciary shall notify the Claimant of the Plan's decision of a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days from the date of receipt of the request for review.

(iii) Post-service Claims. The timing for notification of a decision on appeal varies depending on the Claim Fiduciary. For post-service Claims for which the Claims Fiduciary is a third party, the Claims Fiduciary shall notify the Claimant of the decision of within a reasonable period of time appropriate to the medical circumstances, but in no event later than 60 days from the date of receipt of the request for review. If the Claims Fiduciary has two levels of appeal, the Claimant will receive notice of the decision within 30 days of each level of appeal.

For post-service Claims and eligibility Claims for which the Board of Trustees is the Claims Fiduciary, properly filed appeals will be reviewed at the next regularly scheduled appeals meeting of the Trustees, who meet at least quarterly. However, if the request for review is received within thirty (30) days of the next regular meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. If special circumstances require a further extension of time for processing, a determination will be made at the third regularly scheduled meeting following receipt of the request for review. Prior to the start of the extension, the Claimant or his Authorized Personal Representative will be advised in writing in advance if this extension will be necessary, and will be notified of the special circumstances and the date by which a determination will be made. Once the decision has been made, the Trustees will mail their decision to the Employee or his Authorized Personal Representative within five business days after making the determination. The Trustees' determination on review is binding on all parties.

(g) The Claimant has the right to access and copy (free of charge) all documents, records and other information Relevant to his appeal. A Covered Person has the right to bring a civil action suit under Section 502(A) of ERISA. Any such civil action must be commenced within twelve (12) months following the date of the determination letter.

2. Short Term Disability Claims.

(a) An Adverse Benefit Determination is:

(i) A denial, reduction, a termination of or failure to provide or make a payment in whole or in part, for a benefit; or

(ii) A Rescission of coverage. For this purpose, a rescission of coverage is any cancellation or discontinuance of Plan coverage for Short Term Disability benefits that has a retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions in a timely manner toward the cost of Plan coverage.

The Board of Trustees is the Claims Fiduciary for Short Term Disability Benefits. The Trustees will send the Employee a written notice of the Adverse Benefit Determination for a Short Term Disability Claim.

(b) All appeals must be in writing, on the form required by the Benefit Office, and contain the signature of the Employee or his Authorized Personal Representative.

A written appeal should include evidence or specific facts and Benefit Plan provisions that support a Claim for benefits. An Employee or his Authorized Representative must submit a completed Appeal Form and any additional information to substantiate the appeal to the Benefit Office.

(c) Only an Employee or his Authorized Personal Representative has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries by an Employee or his Authorized Personal Representative for information on whether the Employee qualifies for Short Term Disability Benefits is not considered a Claim for benefits.

(d) If a Claim for Short Term Disability Benefits has been denied, in whole or in part, the Employee or his Authorized Personal Representative have no more than 180 days after the receipt of an adverse benefit determination to file an appeal.

(e) Upon appeal, an Employee has the right to:

(i) Designate an Authorized Personal Representative (who may be an attorney);

(ii) Submit additional material, including comments, statements, or documents;

(iii) Be advised of the identity of any medical expert; and

(iv) Receive copies, free of charge, of:

(A) All new or additional evidence considered, relied upon or generated by the Plan or the Trustees; or

(B) Any new or additional rationale relied upon in connection with the claim.

Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the

Employee or his Authorized Personal Representative a reasonable opportunity to respond.

(f) Preliminary Review. The Benefit Office will complete a preliminary review of a Claim request within five (5) business days of the Fund's receipt of the request for an appeal to determine:

(i) If the Employee was eligible for Short Term Disability Benefits under the Plan;

(ii) The adverse benefit determination does not relate to the Employee's failure to meet the requirements for eligibility under the terms of the Plan; and

(iii) The Employee or his Authorized Personal Representative has completed and provided all of the required information and forms to process the appeal.

If the additional information provided in the course of an appeal is found to clearly fall within the guidelines and protocols for claim payment, additional weekly benefits will be paid on the next following weekly payment cycle for any retroactive time that is approved based on the new information.

In the case of an eligibility reversal, coverage will be updated to cover any additional period of eligibility supported by the additional information provided, and the Employee or his Authorized Personal Representative will be notified of the extension and claims denied for that period will be reopened and reconsidered.

(g) Review of Claim Appeals by the Appeals Committee of the Board of Trustees. Properly filed appeals will be reviewed at the next regularly scheduled appeals meeting of the Trustees, who meet at least quarterly. However, if the request for review is received within thirty (30) days of the next regular meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. If special circumstances require a further extension of time for processing, a determination will be made at the third regularly scheduled meeting following receipt of the request for review. Prior to the start of the extension, the Employee or his Authorized Personal Representative will be advised in writing in advance if this extension will be necessary and will be notified of the special circumstances and the date by which a determination will be made. Once the decision has been made, the Trustees will mail their decision to the Employee or his Authorized Personal Representative within five business days after making the determination. The Trustees' determination on review is binding on all parties.

(h) The Employee or his Authorized Personal Representative has the right to access and copy (free of charge) all documents, records and other information Relevant to his appeal. The Employee has the right to bring a civil action suit under Section 502(A) of ERISA.

3. Other Benefit Claims.

(a) An Adverse Benefit Determination is a denial, reduction, or termination of, or failure to provide or make payment in whole or in part for a benefit.

(b) All appeals regarding Other Benefit Claims must be in writing, contain the signature of the Claimant on the forms required by the applicable Claims Fiduciary and addressed to the applicable Claims Fiduciary.

(c) The written appeal should include evidence or specific facts and Plan provisions that support a Claim for benefits and all of the information required by the applicable Claims Fiduciary on the forms required by the Claims Fiduciary. The Claimant should submit a completed Appeal Form and any additional information to substantiate the appeal to the applicable Claims Fiduciary.

(d) Only a Claimant or, if applicable, his designated beneficiary has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries by a Claimant or, if applicable his designated beneficiary for information on whether a Covered Person qualifies for benefits under the Insured program is not considered a Claim for benefits.

(e) If a Claim has been denied, in whole or in part, the Claimant or, if applicable, his designated beneficiary has no more than ninety (90) days after receipt of an adverse benefit determination to file an appeal.

(f) Upon appeal, a Covered Person or, if applicable, his designated beneficiary has the right to:

(i) Designate an Authorized Personal Representative (who may be an attorney);

(ii) Submit additional material, including comments, statements, or documents.

(g) Review of Appeals: The Claims Fiduciary will review the Claim appeal and provide its written decision within 60 days of receiving the appeal. In some instances the Covered Person or, if applicable, his designated beneficiary will be notified in the original 60 day period that an extension is required and that the Claims Fiduciary will provide a written decision no later than 120 days after receiving the appeal.

(h) The Claimant has the right to access and copy (free of charge) all documents, records and other information Relevant to his appeal. The Covered Person also has the right to bring a civil action suit under Section 502(A) of ERISA.

I. NOTICE OF APPEALS DECISION

When the Plan notifies a Claimant of its decision on a Claim on appeal, it must provide:

1. **For Health Care Claims:**

   (a) The specific reason or reasons for its decision;

   (b) Reference to the specific Plan provisions on which the determination was based;

   (c) 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 to the Claimant's Claim for benefits;

   (d) A statement describing any further appeal procedures offered by the Plan including the Claimant's right to obtain the information about such procedures,

   (e) Copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available at no cost upon request if relevant to a Claim;

   (f) A statement that a copy of the scientific or clinical judgment is available to the Claimant at no cost upon request if Relevant to a Claim that is denied due to a medical judgement which includes but is not limited to:

      (i) Medical Necessity;

      (ii) Experimental or Investigational treatment; or

      (iii) Similar exclusion or limit.

   (g) A statement that if the appeal is denied, the Covered Person has the right to initiate a lawsuit under ERISA Section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal. The notice shall also include the calendar date by which the Covered Person must initiate the lawsuit.

2. **For Health Care Claims except dental and vision:**

   (a) Information sufficient to identify the Claim involved, including: date of service; provider; Claim amount; and any denial codes and their respective meanings; a description of any standard used to determine the denial; and a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge;

   (b) An explanation of the basis for the adverse benefit determination;

   (c) For a Claim based on medical judgement or involving the balance billing protections of the No Surprises Act, to request an external review from an independent review organization after the Plan's Claims appeal procedures have been exhausted.

(d) Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes for Health Care Claims.

3. For Short Term Disability Claims:

(a) The specific reason or reasons for its decision including a discussion of the decision, and, if applicable, an explanation of the basis for disagreeing with or not following:

(i) The views of a health care or vocational professional who treated or evaluated the Employee;

(ii) The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; or

(iii) A disability determination made by the Social Security Administration;

(b) Reference to the specific Plan provisions on which the determination was based;

(c) An explanation of the basis for the adverse benefit determination;

(d) A statement that the Employee is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information Relevant to the Employee's Claim for benefits. Information is considered relevant if it:

(e) Copies of any internal rule, guideline, protocol or similar criteria relied on by the Trustees, or a statement that no such rule, guideline, protocol or similar criteria was considered; and

(f) A statement that the Employee or his Authorized Personal Representative may receive, free of charge, upon request, an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the Employee's medical circumstances, if the Plan's decision is based on a medical necessity, experimental treatment, or similar exclusion or limitation.

(g) A statement that if the Employee's appeal is denied, he has the right to initiate a lawsuit under ERISA Section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal. The notice shall also include the calendar date by which the Employee must initiate the lawsuit.

4. For Other Benefit Claims:

(a) The specific reason or reasons for its decision;

(b) Reference to the specific Plan provisions on which the determination was based;

(c) An explanation of the basis for the adverse benefit determination;

(d) 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 to the Covered Person's Claim for benefits;

(e) A statement that if the Claimant's appeal is denied, the Participant has the right to initiate a lawsuit under ERISA Section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal. The notice shall also include the calendar date by which the Employee must initiate the lawsuit.

J. EXTERNAL REVIEW OF HEALTH CARE CLAIMS

If an appealed Health Care Claim is denied by the Claims Fiduciary, the Claimant may request further review by an independent review organization ("IRO") as described below. External review does not apply to dental and vision claims. Only denied Health Care Claims that involve medical judgment or the balance billing protections of the No Surprises Act and Rescission claims are eligible for external review.

Generally, a Claimant may only request an external review after he has exhausted the internal review and appeals process described above. If a Covered Person's Claim is denied due to his failure to meet the requirements for eligibility under the terms of the Plan, an external review is not available. The External Review of Claims is intended to comply with applicable law and regulations and guidance as issued by the Department of Labor, Department of Health and Human Services and the Internal Revenue Service.

The External Review process is as follows:

1. A request for an external review of a non-urgent Claim must be made, in writing, within four months of the date of the EOB indicating an adverse benefit determination or the date of the letter advising of an adverse appeal Claim benefit determination whichever is later. The Plan's internal review and appeals process generally must be exhausted before an external review is available. External review of a Claim will only apply to an adverse benefit determination or final internal adverse benefit determination involving a medical judgment or the balance billing protections of the No Surprises Act.

2. The Claims Fiduciary will complete a preliminary review of the request within five business days of the Claims Fiduciary's receipt of the Covered Person's external review request to determine whether:

   (a) The Covered Person has exhausted the Plan's internal Claims and appeals process (except, in limited, exceptional circumstances); and

   (b) The Covered Person has completed the proper form to request an external review. Additional information is not required, as the information submitted for the appeal of the denied claim is deemed complete, however if there is additional information available, it may be submitted for consideration.

   The Claims Fiduciary will notify the Claimant in writing within one business day of completing its preliminary review if the request meets the requirements for external review. If applicable, the notification will inform the Claimant that the request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. If the request is complete and eligible, the Claims Fiduciary will assign the request to an IRO and provide, within five business days after the assignment to the IRO, documents and information it considered in making its adverse benefit determination. The IRO is not eligible for any financial incentive or payment based on the likelihood that it would support the denial of benefits. The Claims Fiduciary will rotate assignment among IROs with which it contracts.

4. Once the Claim is assigned to an IRO, the following procedures will apply:

   (a) If additional information is needed, the assigned IRO will notify the Claimant in writing of how to submit additional information regarding the Claim (generally, the Claimant must submit such information within 10 business days following the Claimant's receipt of notice from the IRO).

   (b) If the Claimant submits additional information related to the Claim, the assigned IRO must within one business day forward that information to the Claims Fiduciary. Upon receipt of any such information, the Claims Fiduciary may reconsider its adverse benefit determination that is the subject of the external review. Reconsideration by the Claims Fiduciary will not delay the external review. However, if upon reconsideration, the Claims Fiduciary reverses its adverse benefit determination, it will provide written notice of its decision to the Claimant and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

   (c) The IRO will review all timely received information and documents. In reaching a decision, the IRO will review the Claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Claims Fiduciary's internal Claims and appeals process. However, the IRO will be bound to abide by the terms of the Plan to ensure that the decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must abide by the Plan's requirements for benefits, including:

      (i) The Plan's standards for clinical review criteria,

      (ii) Medical Necessity,

      (iii) Industry standards or appropriateness,

      (iv) Health care setting, or

      (v) Level of care of a covered benefit.

      In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including:

      (vi) Information from the Claimant's medical records,

      (vii) Any recommendations or other information from his treating health care providers,

      (viii) Any other information from the Claimant or the Claims Fiduciary,

(ix) Reports from appropriate health care professionals,

(x) Appropriate practice guidelines,

(xi) The Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(d) After the IRO receives the request for the external review, the assigned IRO will provide written notice of its final external review decision to the Claimant and the Claims Fiduciary within 45 days. The assigned IRO's decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the Claim, including:

(A) the date or dates of service,

(B) the health care provider,

(C) the Claim amount (if applicable),

(D) a statement that the diagnosis and treatment codes, and their corresponding meanings, are available upon request, and

(E) the reason for the previous denial.

(ii) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason(s) for its decision, including the rationale for the decision and any evidence-based standards that were relied upon in making its decision; including:

(A) A statement that the determination is binding except to the extent that other remedies may be available to the Claimant or the Fund under applicable State or Federal law;

(B) A statement that judicial review may be available to the Claimant; and

(C) Current contact information, including phone number, for the health insurance consumer assistance or ombudsman established under law to assist with external review processes.

5. A Claimant may request an expedited external review if:

(a) The Claimant receives an initial adverse benefit determination that involves a medical condition for which the timeframe for completion of an internal appeal would seriously jeopardize his life or health, or would jeopardize his ability to regain maximum function, and the Claimant has filed a request for an urgent care internal appeal; or

(b) The Claimant receives an adverse appeal benefit determination that involves a medical condition for which the timeframe for completion of a standard external review would

seriously jeopardize the his life or health or would jeopardize his ability to regain maximum function; or, the Claimant receives an adverse appeal benefit determination that concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received Emergency services, but has not yet been discharged from a facility.

The process of the expedited external review will not differ from that explained in pages 103-105 but the following time frames will apply.

(c) The Claims Fiduciary's preliminary review will be completed immediately.

(d) The Claims Fiduciary will immediately notify the Claimant whether the request meets the requirements for an external review.

(e) If requirements are met, the Claims Fiduciary will assign an IRO and provide the documents and information it considered in making its adverse benefit determination to the IRO expeditiously.

(f) The IRO will provide a decision in accordance with the requirements of this section within 72 hours. If the notice is not in writing, the IRO must provide written confirmation of its decision within 48 hours of providing the notice.

6. After External Review:

(a) If the final external review reverses the Claims Fiduciary's adverse benefit determination, upon the Claims Fiduciary's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed Claim.

(b) If the final external review upholds the Claims Fiduciary's adverse benefit determination, the Plan will uphold the denial of coverage or payment for the reviewed Claim. If the Claimant is dissatisfied with the external review determination, he may seek judicial review as permitted under ERISA Section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal.

K. POWERS OF THE TRUSTEES, CLAIMS FIDUCIARIES AND OTHER DELEGATES

The Trustees, the Appeals Committee or their designated Claims Fiduciaries, have sole, full and discretionary authority to make final determinations regarding any claim for benefits, the interpretation of the Plan and all documents, rules, procedures and terms of the Plan, and any administrative rules adopted by the Claims Fiduciaries. It is the intention of the drafters of this Plan that the decisions of the Trustees will be accorded judicial deference in any subsequent administrative or court proceeding, to the extent the decisions do not constitute an abuse of discretion. Benefits will only be paid under the Plan if the Trustees or their delegate Claims Fiduciaries decide, in their discretion, that the Claimant is entitled to them.

L. EXHAUSTION OF REMEDIES

Generally, you must follow and completely exhaust the Plan's appeal procedures (including time limits) before you can file a lawsuit under ERISA or initiate proceedings before any administrative agency. If the Plan fails to adhere to all Claims and Claims appeal requirements, you are deemed to have exhausted the Claims appeal process and may seek an external review or file a lawsuit, unless the Plan's failure is minor. In the event you submit a Claim for review and the Claim is denied, any legal action must begin within 12 months of the date the adverse benefit appeal determination is provided.

M. FACILITY OF CLAIMS PAYMENT

In the event the Fund becomes aware that you have been deemed incompetent or incapable of executing a valid receipt and no guardian has been appointed, the Fund may pay any amount otherwise payable to you, to your spouse, or any other person or institution determined by the Fund to be equitably entitled to payment. Any payment in accordance with this provision discharges the Fund from any further obligation.

N. RIGHT TO INFORMATION IN CLAIMS AND APPEALS PROCESS

You have the right to receive, upon written request, copies of all documents relevant to the decision made on your appeal. You may also submit a request to receive the identification of medical or other experts whose advice was obtained for reviewing your appeal. Any and all disclosures will be made in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

COORDINATION OF BENEFITS

If you and/or your Dependents are covered for health care under more than one health plan, this Plan will coordinate benefits with another plan, which means that the total payment from all plans will not exceed 100% of Covered Expenses. "Another plan" means any of the following, whether insured or uninsured, that provide benefits or services for Hospital, medical, prescription drug, hearing, or dental care treatment:

- Group insurance coverage other than school accident-type coverage;
- Group subscriber contracts;
- Coverage through HMOs and other prepayment, group practice and individual practice plans;
- The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts;
- A governmental plan, including Medicare as provided for under the Social Security Act and coverage required or provided by law (such as through the Veterans Administration) but not Medicaid; or
- Individual insurance policies.

This Plan will follow the general Coordination of Benefits (COB) rules that apply throughout the insurance industry. Under COB rules, one plan has "primary" responsibility and is called the primary plan. The primary plan pays benefits first. When a plan pays second, it is called the secondary plan. When there is a third payer, it is called the tertiary plan. This Plan will follow COB rules as follows:

- The plan that covers you as participant is primary. (This applies to eligible Dependents, too. If a Dependent has coverage through his employer, that plan will be his primary plan.)
- If you are married, you and your spouse both work for different employers who offer health coverage, and you have a child eligible for Dependent coverage, the plan of the parent whose birthday (month and day) falls first in the Calendar Year will be the primary plan. If both parents have the same birthday, the plan covering the parent for the longer period of time will be the primary plan.
- If you are covered as a participant under more than one plan, the plan that has been in effect for you the longest will be the primary plan.
- If you are covered as a participant under another group plan and the other group plan contains a provision which excludes you from eligibility due to your coverage under this Plan' shifts coverage liability to this Plan to avoid any liability or to avoid the customary operation of this Plan's COB rules; or modifies, limits, or reduces your benefits because of your coverage under the Plan; this Plan considers such provision(s) to have no effect. As a result, this Plan coordinates benefits payable under this Plan with benefits that would have been payable under the other group plan (as if such provision had not existed).

Coverage of Dependent Children in Divorce Situations

If the parents of a Dependent child are divorced or legally separated, a divorce decree or court order must be furnished to the Plan to ensure proper Coordination of Benefits. The plan of the parent who has responsibility for providing medical insurance for that Dependent as determined by the court order or divorce decree will be primary.

If there is no court order or divorce decree establishing responsibility for providing medical insurance, the plan covering the custodial parent will be the primary plan, the plan covering the spouse of the custodial parent will be secondary, the plan covering the non-custodial parent third and the plan covering the spouse of the noncustodial parent will be last.

Primary coverage by this Plan for stepchildren is provided only in the event that no other person is obligated to provide insurance and no other insurance is available through the biological or adoptive parents' employment. Coverage for stepchildren terminates the last day of the month of the divorce or legal separation.

If your Dependent spouse has other group insurance coverage available at no cost through their employer, this Plan will coordinate with the other plan on the same basis as if the Dependent spouse had elected such coverage.

Insurance for an Adult Dependent Child

If an adult Dependent child under the age of 26 has insurance coverage through his employer, the adult Dependent child's employer plan will pay first and this Plan will pay second.

HMO and POS Coverage Not Used

If your Dependent's primary coverage is a Health Maintenance Organization (HMO) or a Point of Service (POS) and he does not use the HMO or the POS services, no benefits will be paid by this Plan.

Services Provided by the Veterans Administration

The Veterans Administration (VA) is secondary to the Plan when a participant receives treatment at a VA facility for an Illness or Injury not related to Military Service.

Medicare

Health benefits under the Plan for Covered Persons who are also eligible for Medicare will be paid as required by law. Generally, the Plan will be the primary plan and Medicare secondary, in all situations other than End-Stage Renal Disease (ESRD), in which case Medicare is primary after a 30-month coordination period, under most circumstances.

Medicaid

If you are covered under the Plan through your Employer, the Plan is primary to Medicaid.

SUBROGATION AND REIMBURSEMENT

The subrogation and reimbursement provisions for the Fund are described below:

The Fund provides no benefits for Claims of a Covered Person that are related to any Illness or Injury which is caused by third parties or which is Work-Related or the responsibility of any other entity. The Fund will deny any Claim for an Illness or Injury which is caused by third parties, which is Work-Related or the responsibility of any other entity except as otherwise provided in this section on subrogation and reimbursement

If the Fund chooses to advance benefits for the Injuries and Illnesses caused by third parties or that are Work-Related or the responsibility of any other entity, a Covered Person:

1. Upon final adjudication, settlement and/or receipt of case proceeds, agrees to reimburse the Fund up to (i) the amount of benefits paid by this Fund or amounts that the Fund is obligated to pay as well as (ii) any future benefits to be paid relating to the Illness or Injuries caused by the third party or for which a third party is responsible from any recovery received from any third party, insurer or any other source (including but not limited to persons, insurance carriers, estates, special trusts or other entities, hereinafter collectively referred to as "Source") or from any no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, employers' Workers' Compensation insurance policies, personal injury protection coverage, medical payments coverage, financial responsibility, other insurance policies, funds or any other sources of recovery (hereinafter collectively referred to as "Coverage");

2. Agrees, without limiting what is stated in subsection (1) above, to allow the Fund to subrogate against or seek reimbursement with regard to any and all Claims, causes of action or rights that a Covered Person has against any Source who has or who may have caused, contributed to or aggravated the Injuries or conditions for which a Covered Person claims benefits from this Fund and to any Claims, causes of action or rights that a Covered Person may have against any Coverage. The Covered Person agrees to cooperate fully with the Fund in the prosecution of any Claims, causes of action or rights against any Source and/or Coverage;

3. Agrees to enter into a subrogation and reimbursement agreement (hereinafter collectively referred to as "Agreement") that is given to a Covered Person by the Fund, which Agreement the Fund may require before a Covered Person can receive any advancement of benefits (hereinafter collectively referred to as "Advance"). The Fund may withhold benefits until such Agreement is signed. If the Agreement is not executed by the Covered Person(s), at the Fund's request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may refuse to make any Advance. However, in its sole discretion, if the Fund makes an Advance in the absence of an Agreement, or if the Fund makes an Advance in error, that Advance will not waive, compromise, diminish, release or otherwise prejudice any of the Fund's rights to reimbursement or subrogation. The Agreement shall be in a form provided by or on behalf of the Fund. If the Covered Person is a minor or incompetent to execute that Agreement, that person's parent, the Participant (in the case of a minor Dependent child), the Participant's spouse, or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Fund. A Covered Person must comply with all of the terms of the subrogation and reimbursement agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Covered Person agrees that out of any recovery he receives from any Source or Coverage, as described in subsection (1) above,

the identified amount that the Fund has Advanced or is obligated to Advance in benefits will be immediately deposited into a trust for the Fund's benefit and the Fund shall have an equitable lien by agreement in the amount set forth in this paragraph which shall be enforceable as part of an action to enforce the Plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed;

4. The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Covered Person, as opposed to the general assets of the Covered Person, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be traced to a specific account or other destination after they are received by the Covered Person;

5. The Agreement will grant the Fund a priority, first dollar security interest and a lien in any recovery received from any Source or from any Coverage, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Illness or Injury;

6. Acknowledges that the Fund specifically disavows the common fund doctrine, attorneys fund doctrine, fund doctrine, the double-recovery rule or any similar doctrine or theory, including the contractual defense of unjust enrichment. This means that the Fund's subrogation and reimbursement rights apply on a priority, first dollar basis to any recovery by the Covered Person from any Source or Coverage without regard to legal fees and expenses of the Covered Person. This also means the Covered Person will be solely responsible for paying all legal fees and expenses in connection with any recovery from any Source or Coverage for the underlying illness or injury, and the Fund's recovery shall not be reduced by such legal fees or expenses;

7. Acknowledges that the Fund specifically disavows the make-whole rule or any other similar doctrine or theory. This means that the Fund's subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery by a Covered Person from any Source or Coverage, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the Covered Person believes he did not receive the amount that he is entitled to receive, or if the amounts are categorized or described as medical expenses or as amounts other than for medical expenses;

8. Agrees that if the recovery is reduced due to a Covered Person's negligence (sometimes referred to as contributory negligence) or any other common law defense, the amount of the Plan's reimbursement is not affected or reduced;

9. Agrees that the Fund's right to reimbursement applies regardless of the existence of any state law or common law rule (including, but not limited to, the Missouri Workers' Compensation Law, M.O. Stat. §286.010, et seq.) that would serve to ban or limit recovery of the Advance by the Fund from the Covered Person or from any other Source;

10. Agrees that the Fund's right to reimbursement applies regardless of the existence of any state law or common law rule that would ban recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);

11. Agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Fund's reimbursement rights or subrogation rights;

12. Agrees to notify and consult with the Fund or its designee in writing before starting any legal action or administrative proceeding against a Third Party alleged to be responsible for the Illness or Injury that resulted in the Advance, and before entering into any settlement agreement with that Third Party or Third Party's insurer based on those allegations;

13. Agrees that the Fund has the right to suspend all benefit payments due to the Covered Person and family member of the Covered Person arising out of the current incident or any other unrelated future illness or injury until the Fund is fully reimbursed related to the Covered Person;

14. Recognizes that no loan transaction is intended to be created under any subrogation or reimbursement agreement; and

15. Agrees not to assign a Covered Person's rights with respect to subrogation and reimbursement to anyone (except as otherwise stated in this section). This means that a Covered Person cannot give anyone else the right to pursue whatever rights that a Covered Person has or had with respect to subrogation and reimbursement. Any attempt to do so will be void and have no effect.

For purposes of these provisions on subrogation and reimbursement, the term "Covered Person" shall also include representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of or for Covered Persons.

The Fund's subrogation and reimbursement rights and the Covered Person's obligation set forth above shall apply regardless whether the Covered Person executes a subrogation and reimbursement agreement.

For purpose of the subrogation and reimbursement provisions, benefits that are paid for medical, Hospital, Dental, Vision, Prescription Drug and the Short Term Disability benefit (except relating to an accelerated death benefit) are recoverable through subrogation or reimbursement.

Recovery of Erroneous or Fraudulent Claims

The Fund will pay claims only when covered under the terms of the Plan provisions under which you are eligible. If the Fund pays Claims that it is not required to pay, it may recover and collect payments from you or any other entity or organization that it was required to make the payment to or that received an erroneous payment. The Fund will be permitted to pursue legal and equitable remedies to recover overpayments. The Fund may recover such erroneous payments and related amounts by offsetting or reducing any future benefit amounts payable to the Covered Person and eligible dependents of the Covered Person.

You and your eligible dependents may lose eligibility for coverage if you knowingly commit fraud against the Plan, for example, by filing claims for benefits to which you are not entitled, or for failing to report other available benefits coverage or your rights against a third party or Insurance Company in connection with a health Claim, and will be required to repay any monies paid. You may also be subject to legal action by the Fund.

IMPORTANT NOTICES

A. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

You or your Dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed or aesthetic flat closure surgery;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, Deductibles, Co-payments, and Coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Benefit Office.

B. COVERAGE FOR MATERNITY HOSPITAL STAY

Under federal law, the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider, in consultation with the mother of the newborn, from discharging the mother or newborn earlier than 48 or 96 hours, as appropriate.

C. PRIVACY OF HEALTH INFORMATION

Under federal law, the Plan protects your health information and keeps it strictly confidential. This includes protecting your health information from unauthorized disclosure. Health information includes personal health information that is transmitted or maintained by electronic media or in any other format. You will receive a notice of the Plan's practices and procedures regarding protecting health information, or you may obtain a copy of the Plan's Privacy Notice at benefits@laborfunds.org.

In general, the Plan will use or disclose your health information only for treatment, payment or health care operations. The Plan will disclose your health information for other purposes only if you authorize this disclosure. You are entitled to know when and to whom disclosure has been made for any reason that is not for treatment, payment and health care operations, with certain exceptions.

The Plan will disclose your health information to you. You will be allowed to inspect and obtain a copy of your information, except for psychotherapy notes. You have the right to amend and correct your own health information.

The Plan will not use or disclose health information without the consent or authorization of the patient, except as required or permitted under the law.

In the unlikely event that your protected health information is breached, the Plan will comply with breach notification rules under the Health Insurance Portability and Privacy Act ("HIPAA").

In the administration of the Plan, the Plan will make every effort to use only summarized health information or to only disclose health information that has been stripped of all identifying data. The Plan will take all necessary steps to ensure that health information is not used to perform any function that is not related to the Plan.

To protect your health information, the Plan has designated a privacy officer, to ensure that all health information is protected. Reasonable administrative, physical and technical safeguards are in place to protect against intentional or accidental disclosure or misuse. The Plan makes every attempt to ensure that any agent, vendor, subcontractor, etc., to whom it provides health information agrees to do the same, and to report to the Plan any security incident. If possible, the Plan will return or destroy your health information when it is no longer needed for the purpose for which the disclosure was made.

If you believe that your health information has been misused or disclosed when it should not have been disclosed, you may contact the Privacy Officer of the Plan to challenge or dispute the use or disclosure of your health information. If the Plan determines that your health information has been misused or disclosed to anyone who should not have received it, then the Plan will do everything possible to minimize any harm that has been done. The Plan makes every effort to ensure that its vendors, subcontractors or any individual that performs any function for the Plan or assists the Plan in any function, protect your health information in the same way.

Appendix I

GENERAL PLAN DEFINITIONS

Unless indicated otherwise in a specific context, words used in this booklet shall have the meanings set forth below. 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"** is the class of coverage for Bargained Employees, Non-Bargained In-House Employees, Non-Bargained Office Employees whose eligibility results from employer contributions pursuant to a CBA or Participation Agreement, Minimum/Difference self-payments, or COBRA self-payments.

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. **"Acute"** refers to an Illness or Injury that is both severe and recent onset.

4. **"Allied Health Professionals"** means Nurse Practitioners (NP), Certified Registered Nurse Anesthetists (CRNA), Physician Assistants (PA) and Certified Nurse Midwives (CNM) with respect to the services of such Providers specifically covered by the Plan and to the extent that such services are within the scope of the Provider's legally authorized practice and rendered under the direction of a Physician.

5. **"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

6. **"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.

7. **"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.

8. **"Apprentice"** refers to a Bargained Employee who is an apprentice with the Mid-America Carpenters Regional Council Apprentice and Training Centers

9. **"Bargained Employee"** refers to those individuals represented by a CBA.

10. **"Basic Plan"** refers to the benefits offered to eligible Apprentices during the first four terms of apprenticeship. The following benefits are provided through the Basic Plan: medical, prescription drugs, dental, vision, life and AD&D.

11. **"Benefit Quarter"** means any of the three-month periods beginning January 1, April 1, July 1, and October 1 of each year.

12. **"Carpenters' Pension Plans"** refers to the Pension Plan of the Carpenters' Pension Trust Fund of St. Louis, the Carpenters' Pension Trust Fund of Kansas City, Kansas Construction Trades Open End Pension Trust Fund or the Carpenters Pension Fund of Illinois (Geneva).

13. "**Child**" is defined in means any of the following, provided that in each case the child satisfies the definition of Child or Dependent under Internal Revenue Code section 105(b):

    (a) A biological child through the end of the month in which the child attains age 26;

    (b) A child adopted by or placed for adoption with a Participant through the end of the month in which the child attains age 26;

    (c) An Alternate Recipient under a QMCSO;

    (d) A Participant's step-child, provided that the child's biological parent is the Participant's Spouse, through the end of the month in which the child attains age 26;

    (e) A Participant's Totally and Permanently Disabled Child age 26 and older provided the following conditions are met:

        (i) The Child was Totally and Permanently Disabled on their 26th birthday;

        (ii) The Participant is entitled to and does claim a deduction for the Child on the Participant's federal income tax return;

        (iii) No later than 63 days after the later of the Child's 26th birthday or the Participant's eligibility date, and as often thereafter as requested by the Plan, the Participant provides proof that the forgoing conditions existed on the Child's 26th birthday and continuously thereafter.

14. **"Claim"** means a demand for payment under the Plan on behalf of a Claimant pursuant to the procedures for making such requests set forth in the Plan Document.

15. **"Claimant"** means a Covered Person who requests a benefit to be paid to him under the procedures set forth in the Plan Document. A Claimant includes a Participant or the Participant's spouse, Participant's Dependent, or the Participant's Personal Representative authorized by the Covered Person.

16. **"Claims Fiduciary"** means the entity that has full discretionary authority to interpret the terms of the Plan and to decide benefit claims under the Plan and the appeal of such decision, and to maintain any applicable external review process. The Plan's Claims Fiduciary is the Board of Trustees unless the Trustees take action to delegate such authority to a third party Claims

Fiduciary such as to an insurance carrier or to a third party service provider responsible for maintaining a benefit program under the Plan, *e.g.*, a service provider maintaining the Plan's dental, vision, behavioral health, prescription drug or medical benefits as designated in this Summary Plan Description.

17. **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

18. **"Coinsurance"** is a portion, expressed as a percentage, of Covered Charges a Covered Person must pay for a service for a service or supply as defined by the benefit schedule.

19. **"Collective Bargaining Agreement" or "CBA"** is the written legal contract between the Union and an Employer.

20. **"Continuing Care Patient"** means a Covered Person who:

    (a) Is undergoing a course of treatment for a serious and complex condition from a Provider. A "serious and complex condition" means, for this purpose, (1) an Illness that requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) a chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time; and

    (b) Is either:

        (i) Undergoing a course of institutional or inpatient care from the Provider;

        (ii) Is scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care from such Provider with respect to such a surgery;

        (iii) Is pregnant and undergoing a course of treatment for the pregnancy from the Provider; or

        (iv) Was determined to be terminally ill and is receiving treatment for such Illness from the Provider.

21. **"Continuing Care Services"** means items and services provided to a Continuing Care Patient by a Non-Network Provider that relate to the Covered Person's current course of treatment and status as a Continuing Care Patient. The Plan will cover Continuing Care Services for up to a 90-day period beginning on the later of the date of the Plan's Continuity of Care Notice or the date the Provider leaves the Network and ending on the earlier of the 90-day period or the date the Covered Person's current course of treatment ends.

22. **"Contracted Provider"** means an organization with which the Plan contracts for services on behalf of Participants and Covered Persoons, including, but not limited to provisions of a Preferred Provider Network, Utilization Review management, and other services related to Plan benefits.

23. **"Contribution Quarter"** means any of the three-month periods beginning February 1, May 1, August 1, and November 1 of each year.

24. **"Copayment"** or **"Copay"** is a specified fixed dollar amount a Covered Person must pay as a condition of the receipt of certain services as provided in the Plan.

25. **"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.

26. **"Covered Person"** is a Participant and/or Dependent, who is eligible for benefits under the Plan.

27. **"Credit Hour"** means 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.

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

29. **"Dependents"** refer to a Participant's Child or Spouse.

30. **"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 not 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.

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

32. **"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.

33. **"Emergency"** means a severe condition that:

    (a) Results from symptoms that occur suddenly and unexpectedly and are Non-Occupational;

    (b) Poses an imminent serious threat to a Covered Person's health; or

    (c) Requires immediate Physician's care to prevent death or serous impairment of health.

34. **"Emergency Room"** means the section of a legally licensed Hospital facility staffed and equipped to provide immediate treatment for victims of sudden Illness, Injury or trauma.

35. **"Emergency Services"** means, with respect to an Emergency, any medical screening examination, medical examination and treatment necessary to evaluate and to stabilize the patient, and any post-stabilization services rendered to a patient admitted through an Emergency Room. Post-stabilization services include items and services provided by a Non-Network Provider that the Plan would cover if furnished by a Network Provider after the Covered Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Room visit

    Post-stabilization services that meet the following requirements shall not be considered Emergency Services:

    (a) The attending emergency Provider determines the Covered Person is able to travel using nonmedical transportation or nonemergency medical transportation to an available Network Provider located within a reasonable travel distance, taking into account the individual's medical condition;

    (b) The Non-Network Provider furnishing such additional items and services satisfies the notice and consent requirements of the No Surprises Act;

    (c) The Covered Person (or a person authorized by law to provide consent on their behalf) is in a condition to receive the required notice under the No Surprises Act and to provide informed consent; and

    (d) The Non-Network Provider satisfies any additional requirements or prohibitions imposed under state law.

36. **"Employee"** means any individual employed by an Employer:

    (a) In a bargaining unit represented by the Union for whom the Employer is obligated to contribute to the Plan pursuant to a Collective Bargaining Agreement; or

(b) For whom the Employer is obligated to contribute to the Plan pursuant to a written Participation Agreement or other written agreement.

(c) Sole proprietors, partners and other unincorporated owner/operators do not qualify as "Employees."

37. **"Employer"** has the meaning assigned to it in the Trust Agreement.

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

39. "**ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or successor provisions of any legislation that amends, supplements, or replaces such section or subsection.

40. **"Excepted Benefit"** means the designated benefit is exempt from certain group health plan requirements, including Health Insurance Portability and Accountability Act portability requirements, Affordable Care Act, Mental Health Parity and Addiction Equity Act, and the Consolidated Appropriations Act, 2021.

41. **"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.

(i) 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.

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

42. **"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.

43. **"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.

44. **"Grandfathered In House Employees"** Non-Bargained In-House Employees hired prior to January 1, 2024, for whom hourly contributions are required to this Plan.

45. **"Home Health Agency"** means a program of care provided by a public agency or private organization or a subdivision of such agency or organization that:

(a) Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;

(b) Has established policies for governing the services it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses;

(c) Provides for the supervision of its services by a Physician or registered professional nurse acting under a Physician's direction;

(d) Maintains clinical records of all patients;

(e) Is licensed according to the applicable law of the state in which it is located or provides services;

(f) Is certified or approved by Medicare and is eligible to participate under Medicare; and

(g) Is not primarily for the care of Behavioral Health and/or Substance Use Disorders.

46. **"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.

47. **"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.

48. **"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 Person.

49. **"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.

50. **"Illness"** means a sickness, disorder, or disease that is Non-Occupational. Pregnancy is included in the definition of "Illness" under this Plan. All Illnesses that are due to the same or related cause or causes will be deemed one Illness.

51. **"Injury"** means any damage to a body part resulting from a Non-Occupational trauma from an external source.

52. **"In-Network Provider"** or **"Network Provider" or "Network"** 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.

53. **"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.

54. **"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.

55. **"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 Person or the comfort and convenience of the Physician.

    (g) Not Experimental or Investigational as determined by the Plan.

56. **"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.

57. **"Military Service"** means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty. Military Service covers the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

58. **"Network Sponsor"** means a group of independent Doctors, Hospitals, pharmacies or other health care providers who have agreed to contract with a single organization with which the Plan contracts for services.

59. **"No Surprises Act"** means the No Surprises Act portion of the Consolidated Appropriations Act, 2021, its implementing regulations and other underlying guidance.

60. **"Non-Active Classification"** is the class of coverage for Bargained Employees, Non-Bargained In-House Employees, Retired Participants, Non-Pension Participants, Disabled Participants and Surviving Spouses who self-pay for coverage.

61. **"Non-Bargained In-House Employee"** means Employees of the following Employers who have executed a Participation Agreement for Non-Bargained In-House Employees:

    (a) Mid-America Carpenters Regional Benefit Services, Inc.

    (b) Mid-America Carpenters Regional Council (limited to those Employees working as part of the regions covered by the Southern Region Benefit Plan)

    (c) Mid-America Carpenters Regional Council Apprentice and Training Centers (limited to those Employees working as part of the regions covered by the Southern Region Benefit Plan)

62. **"Non-Bargained Office Employee"** means any Employee, other than a Bargained employee or a Non-Bargained In-House Employee, of an Employer who executes a Participation Agreement for Non-Bargained Office Employees and is accepted by the Trustees.

63. **"Non-Occupational"** or **"Non-Occupational Illness or Injury"** means:

    (a) Any Injury that does not arise out of or in the course of the Covered Person's employment; or

    (b) Any Illness that is not caused or aggravated by employment, for which benefits are not payable in whole or in part under any Workers' Compensation Law, Employer's Liability Law, Occupational Disease Law, or similar law.

64. **"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 Plan due to a Participation Agreement or CBA.

65. **"Occupational Therapy"** means the use of work-related skills to treat or train the Covered Person, to prevent disability, and to restore the Covered Person to health, social or economic independence.

66. **"Out-of-Network"** or **"Non-Network Provider"** means Physicians, Hospitals, or other health care providers who do not participate in the Networks of the Plan's Contracted Providers.

67. **"Out-of-Pocket Maximum"** means the maximum amount that a Covered Person is required to pay for Covered Expenses within a specified period of time. After a Covered Person satisfies the Plan's applicable Out-of-Pocket Maximum, the Plan will pay one hundred percent (100%) of any additional Covered Expenses a Covered Person incurs for the remainder of the Calendar Year.

68. **"Participant"** refers to those Employees who are eligible for benefits, 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.

69. **"Participation Agreement"** means a written agreement between an Employer (as defined in the Trust Agreement) and the Trustees, in which the Employer agrees to become an Employer hereunder obligating the Employer to make contributions to the Plan on behalf of the Employer's covered Employees whether or not subject to the terms of a Collective Bargaining Agreement. The

Trustees may also enter Participation Agreements with Employers covering independent contractors retained by the Employer.

70. **"Pharmacy Benefit Manager and Network Sponsor"** means the organization with whom the Plan has contracted with to administer the Prescription Drug Program.

71. **"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.

72. **"Physician" "Physician"** or **"Doctor"** means an individual licensed in the state where such individual renders treatment and/or is acting within the scope of his license at the time and place the services are performed; including, but not limited to a: Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Science/Surgery (DDS), Doctor of Medical Dentistry (DMD), Doctor of Optometry (OD), Doctor of Ophthalmology (MD-Ophthalmology), Doctor of Chiropractic Medicine (DC), and a Doctor of Psychology (PsyD). Additionally, to the extent required by the Affordable Care Act and available guidance, if an individual's service is covered under the Plan, the Plan will not discriminate based on the practitioner's license or certification, if the practitioner is licensed to provide such services in the state in which the services are performed and the practitioner is acting within the scope of that license.

73. "**Plan,**" **"Benefit Plan," "Plan of Benefits"** or **"Health Plan"** means this Mid-America Carpenters Regional Council Health Plan or the plan or program of benefits provided by the Plan set forth in the Plan document, including any other written document designated by the Trustees as constituting a part of the Plan, established, and as it may be amended from time to time by the Board of Trustees pursuant to the provisions of the Trust Agreement.

74. **"Plan Year"** means the twelve (12) month period beginning on July 1 of any year and ending the following June 30.

75. **"Pregnancy"** means the state of being pregnant, childbirth, miscarriage, and any complications arising from any of these conditions.

76. **"Premium"** is the monthly fee required for certain classes of coverage under the Plan.

77. **"Premium Plan"** refers to the benefits offered to Participants and their Dependents, other than Apprentices in their first through fourth term covered in the Basic Plan. The following benefits are provided through the Premium Plan: medical, prescription drugs, dental, vision, disability, life and AD&D.

78. **"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).

79. **"Primary Care Physician"** or **"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.

80. **"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.

81. **"Protected Services"** means:

    (a) Emergency Services furnished by a Non-Network Provider;

    (b) Air ambulance services furnished by a Non-Network Provider;

    (c) Non-emergency items and services, such as anesthesiology, pathology, radiology, diagnostic services, and other services defined as ancillary services under the no Surprises Act furnished by a Non-Network Provider at a Network facility;

    (d) Other items and services furnished by a Non-Network Provider at a Network Hospital, Hospital outpatient department, or ambulatory surgical center if such items and services would be covered by the Plan if furnished by a Network Provider and the Provider does not satisfy the notice and consent requirements of the No Surprises Act.

82. **"Provider"** means a Physician, Hospital, or other Provider of medical care, services, or supplies, including Allied Health Professionals. All providers must be licensed to provide services within the scope of their license by the state in which the services are rendered.

83. **"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 "Medical Child Support Order" is any judgment, decree, or order (including approval of a settlement agreement) which:

    (a) 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

    (b) is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

84. **"Retired Participant"** mans an individual who meets all of the following requirements: as defined in Section I.C.2.(f).

    (a) Has begun receiving pension benefits from any of the Carpenters' Pension Plans,

(b) Had a previous period of coverage as a Bargained Employee or Non-Bargained In-House Employee, and

(c) Is neither a retired Self-Employed Participant, a retire Non-Pension Participant, a Disabled Participant, nor a Surviving Spouse.

85. **"Select Specialty Medication"** means a medication that is designated as a non-essential health benefit under the Affordable Care Act by the Plan's Contracted Provider. Select Specialty Medications are subject to the Specialty Pharmacy Copay Assistance Program.

86. **"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.

87. **"Spouse"** means The Participant's lawful spouse, as recognized under applicable state law and in a manner consistent with governing Federal law and for whom all required documentation is submitted, if not legally separated or divorced from the Participant.

88. **"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.

89. **"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.

90. **"Trust Agreement"** means the Mid-America Carpenters Regional Council Health Fund Trust Agreement as amended from time to time, establishing the Trust Fund and its rules of operation.

91. **"Trust Fund"** or **"Fund"** means the Mid-America Carpenters Regional council Health Fund.

92. **"Trustee," "Trustees,"** or **"Board of Trustees"** means a Trustee or the Trustees of the Mid-America Carpenters Regional Council Health Fund

93. **"Union"** or **"Council"** means the Mid-America Carpenters Regional Council of the United Brotherhood of Carpenters and Joiners of America and affiliated local Unions as identified in the Trust Agreement.

Appendix II

A. ADMINISTRATIVE PLAN INFORMATION

Plan Name	The Plan is the Mid-America Carpenters Regional Council Health Fund.
Plan Sponsor and Plan Administrator	A Board of Trustees is responsible for the operation of the Plan. Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrator. The Administrator and the Fund staff, under the Administrator's supervision, maintain eligibility records, account for employer contributions, answer participant inquiries, process Claim and benefit payments and handle other administrative functions.
Trust Fund	The Board of Trustees holds all assets in trust pursuant to the Trust Agreement. All benefits and administrative expenses are paid from the Fund's assets except for Life Insurance and Accidental Death and Dismemberment Insurance benefits under the Plan. The Trust Agreement consists of all the documents, including all amendments that establish the Trust Fund and its rules of operation.
Employer Identification Number	36-2229735
Plan Number	501
Plan Type	The Plan is an employee welfare benefits plan maintained to provide medical, prescription drug, dental, vision, disability, life and accidental death and dismemberment insurance for those who meet the eligibility requirements described in this SPD.
Plan Year	July 1 – June 30
Type of Funding	The benefits described in this SPD are self-funded except for Life Insurance and Accidental Death and Dismemberment Insurance benefits under the Plan, which are currently insured by Metropolitan Life Insurance Company. All self-funded benefits are limited to the Plan's assets available for payment of such benefits
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	For disputes arising under the Plan, service of legal process may be made on: Kristina M. Guastaferri, Executive Director Mid-America Carpenters Regional Council Health Fund 12 E. Erie Street Chicago, IL 60611 312-787-9455 Service of any legal process may also be made on any individual Trustee at the address for the Fund Office.

Amendment and Termination	The Board of Trustees has the right to amend or terminate the Plan in whole or in part at any time.		
Claims Fiduciary	Medical Benefits UMR P.O. Box 8046 Wausau, WI 54402 www.UMR.com	Member Assistance Program Mercy Managed Behavioral Health 1000 Des Peres Road, Suite 200 St. Louis, MO 63131 www.mbh-eap.com	Dental Benefits Delta Dental of Missouri P.O. Box 8690 St. Louis, MO 63126 www.deltadentalmo.com
	Prescription Drug Benefits Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417 www.express-scripts.com	Specialty Prescription Drug Benefits Accredo Pharmacy PO Box 954041 St Louis, MO 63195 www.accredo.com	Vision Benefits VSP 3333 Quality Drive Rancho Cordova, CA 95670 www.vsp.com
	Life and AD&D Insurance MetLife Attn: Life Claims Department P. O. Box 6115 Utica, NY 13504-6115 www.metlife.com		
No Vesting	No benefits vest under the Fund.		
Restatement Date of SPD	This SPD is effective as of July 1, 2025.		
Plan Administrator	Breanna Radtke Mid-America Carpenters Regional Council Health Fund 12 East Erie Street Chicago, IL 60611		
Board of Trustees	**Union Trustees**	**Employer Trustees**	
	Gary Perinar MACRC of the United Brotherhood of Carpenters and Joiners of America 12 East Erie Street Chicago, IL 60611	Gerald W. Thiel, Jr. G.W. Thiel, Inc. 2872 Corporate Parkway Algonquin, IL 60102	
	Kevin McLaughlin MACRC of the United Brotherhood of Carpenters and Joiners of America 12 East Erie Street Chicago, IL 60611	Mike Forest RB Construction, Inc. 220 Gerry Drive – Suite 100 Wood Dale, IL 60191	
	Wade Beasley MACRC of the United Brotherhood of Carpenters and Joiners of America 12 East Erie Street Chicago, IL 60611	Kevin Geshwender Berglund Construction 8410 South Chicago Chicago, IL 60617	
	Rocky Kloth Mid-America Carpenters Regional Council 8955 E. 38th Terrace Kansas City, MO 64129	Gerhard Glassl The Up Companies 2060 Craigshire Road St. Louis, MO 63146	

	Steve Pinkley Mid-America Carpenters Regional Council 1401 Hampton Avenue St. Louis, MO 63139	Brian Murphy BAM Contracting, LLC 2342 LaSalle Street St. Louis, MO 64106
	Joel Pogose MACRC of the United Brotherhood of Carpenters and Joiners of America 12 East Erie Street Chicago, IL 60611	Mike Sudol Bulley & Andrews LLC 1755 Armitage Avenue Chicago, IL 60622
No Guarantee of Employment	Your coverage by the Plan does not constitute a guarantee of your continued employment.	
Plan Inspection	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.	

B. 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.

C. DISCRETIONARY AUTHORITY

The Trustees have the power and authority to amend or terminate the Plan, to increase, decrease, or change benefits and premiums, or change eligibility rules or other provisions of the Plan of Benefits for the Premium Plan and the Basic Plan, 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.

D. PLAN AMENDMENT AND PLAN TERMINATION

Any amendment made by the Trustees will be reduced to writing and may be effective prospectively or retrospectively, to the extent allowed under the law, provided, however, no amendment to the Plan will retroactively reduce benefit entitlement or benefit levels then in effect. All amendments are subject to the limitation of the Trust Agreement and the applicable law and administrative regulations. The Trustees reserve the right to terminate the Plan or any part of the Plan and its benefits at any time. Written notice of amendment or termination of the Plan will be provided to you in accordance with federal regulations.

E. FURNISHING REQUIRED INFOMRATION 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 or omits information 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.

F. YOUR RIGHTS UNDER ERISA

As a participant in the Mid-America Carpenters Regional Council Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (SAR).

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 summary plan description 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a 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 do not receive them within 30 days, you may file suit in a 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan 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, 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

	SHORT-TERM DISABILITY BENEFIT	LIFE INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT
ACTIVE CLASSIFICATION			
Bargained Employees (1st - 4th Term Apprentices) and Dependents	√ Participant Only	√	√ 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

	SHORT-TERM DISABILITY BENEFIT	LIFE INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT
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 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 IV – Schedules of Benefits

SCHEDULE OF BENEFITS – PREMIUM PLAN

This Schedule of Benefits applies to Covered Persons in the Premium Plan.

- The amounts charged for Covered Charges are subject to the Allowable Amount.
- The deductible applies to all Covered Charges unless specifically noted.
- Coinsurance amounts set forth below reflect the amount paid by the Plan. All other cost-sharing reflects amounts paid by the Covered Person.

COMPREHENSIVE MEDICAL BENEFITS		
	Network Provider	**Non-Network Provider**
Coinsurance	80% paid by Plan	50% paid by Plan
	Protected Services and Continuing Care Services are payable at the Network Provider rate	
Deductible per Calendar Year	$300/Covered Person $900/Family	$2,000/Covered Person $6,000/Family
	Network and Non-Network Deductibles are separate and cannot be combined. Protected Services and Continuing Care Services accumulate to the Network Deductible.	
Out-of-Pocket Maximum per Calendar Year	$2,800/Covered Person $8,400/Family	$90,000/Covered Person Unlimited/Family
	After a Covered Person satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Charges for the remainder of the Calendar Year. Network and Non-Network Out-of-Pocket Maximum are separate and cannot be combined. Protected Services and Continuing Care Services accumulate to the Network Out-of-Pocket Maximum.	
SPECIFIC COVERAGE AMOUNTS		
Office Visits		
Primary Care Physician	$25 Copay Deductible does not apply	50%
Specialist	$50 Copay Deductible does not apply	50%
Mental Health and Substance Abuse	$25 Copay Deductible does not apply	50%
Telehealth Connection Services and Teladoc	100% Deductible does not apply	Not covered
Preventive Care	100% Deductible does not apply	50%
Breast feeding equipment and supplies	100% Deductible does not apply	Not covered
	Limited to purchase of one breast pump per birth (single or multiple) or rental of one breast pump per birth. Non-Network Provider coverage payable at the Network Provider rate if no Network Provider is available.	

COMPREHENSIVE MEDICAL BENEFITS			
	Network Provider		**Non-Network Provider**
Outpatient Services			
Outpatient surgery	**Center of Excellence**	**Network Provider**	**Non-Network Provider**
	90%	80%	50%
Hearing Aid	80%		80%
	Maximum $2,000/ear every 5 years		
Labs	**LabCorp/Quest**	**Network Provider**	**Non-Network Provider**
	100% Deductible does not apply	80%	50%
Scans and Diagnostic Services	**Freestanding Facility**	**Network Provider**	**Non-Network Provider**
	$25 Copay Deductible does not apply	80%	50%
	Freestanding Facility means a facility not owned by a hospital or physician group. Scans and diagnostic services includes but is not limited to: radiology, x-ray, anesthesia, pathology, CT, PET, MRI, nuclear scans. Protected Services payable at the Network Provider rate.		
Physical, Speech, and Occupational Therapy	$25 Copay Deductible does not apply		50%
	Limited to 60 visits combined each Calendar Year.		
All other therapies, including cognitive therapy and pulmonary rehab	80%		50%
	Limited to 60 visits combined each Calendar Year		
DME, Orthotics and Prosthetics	80%		50%
	Foot orthotics maximum $1,000 per Calendar Year		
Home Health Services and Hospice	80%		50%
Chiropractic Care	$10 Copay Deductible does not apply		50% Deductible does not apply
	Limited to 40 visits each Calendar Year		
Inpatient Services			
Hospital Services	80%		50%
Skilled Nursing Facility, Extended Care Facility, Convalescent or Subacute Facility	80%		50%
	Limited to 100-day maximum cross accumulates among all benefit levels		
Mental Health and Substance Abuse Residential Care	80%		50%
Observation Room	80%		50%
Physician Hospital Visits and Specialist Care/Consultations	80%		50%
Other Services	80%		50%
	Other services include, but are not limited to, emergency room, radiology, anesthesiology, and pathology. Protected Services are payable at the Network Provider rate.		

COMPREHENSIVE MEDICAL BENEFITS		
	Network Provider	**Non-Network Provider**
Emergency and Urgent Care		
Hospital Emergency Room	$250 Copay then 80% paid by Plan Deductible does not apply	$250 Copay then 80% paid by Plan Deductible does not apply
	Copay waived if admitted within 24 hours of initial emergency room visit or after a period of continuous observation that is less than 72 hours; standard Deductible/coinsurance would then apply. Copay includes any continuous observation (but less than 72 hours) prior to any admission.	
Urgent Care Facility	$75 Copay Deductible does not apply	50%
Ambulance Services – Ground	$150 Copay Deductible does not apply	$150 Copay Deductible does not apply
Ambulance Services - Air	$1,000 Copay Deductible does not apply	$1,000 Copay Deductible does not apply

DENTAL BENEFITS			
	PPO Network	**Premier Network**	**Non-Network**
Deductible per Calendar Year			
Preventive Services	None	$50	$150
All Other Services	$50	$75	$150
Annual Maximum* (excluding orthodontia services)	MaxAdvantage† plus $2,000	MaxAdvantage† plus $2,000	MaxAdvantage† plus $2,000
Preventive Services	100%	75%	50%
Basic Services	80%	50%	25%
Major Services	50%	40%	25%
Orthodontic Services	50%	50%	50%
Lifetime Maximum	$4,000		
* Per Covered Person age 19 and older. Annual maximum does not apply to Covered Persons age 18 and younger. † See pages 71-72 for MaxAdvantage services that are excluded from the annual maximum.			

VISION BENEFITS		
	Network Provider	**Non-Network Provider**
Routine Eye Exam	$10 Copay	Greater of $10 Copay or balance after Plan pays $38
Frames	$25 Copay then Plan pays 100% up to $150 and 20% of balance	Greater of $25 Copay or balance after Plan Pays $45
	Limited to one frame every 24 months	
Lenses		

Single Vision	100%	Plan pays $31
Lined Bifocal	100%	Plan pays $51
Lined Trifocal	100%	Plan pays $64
Lenticular	100%	Plan pays $80
	Limited to one set of lenses per calendar year	
Lens Enhancements		
Standard Progressive	Plan pays $50	Not covered
Premium Progressive	Plan pays $80-$90	Not covered
Custom Progressive	Plan pays $120-$160	Not covered
	Limited to one per calendar year	
Contact Lenses		
Medically Necessary in lieu of glasses	100%	Plan pays $210
Elective	Plan pays $150, including lens exam	Plan pays $105, excluding lens exam
	Limited to once per calendar year	
Protec Safety Frames and Lenses	$25 Copay	Not covered
	Limited to one frame every 24 months	

SHORT-TERM DISABILITY BENEFIT		
Short-Term Disability Benefit	**Weekly Indemnity**	$550 per week
	Maximum Benefit	26 weeks
Maternity Leave Benefit	**Weekly Indemnity**	$800 per week
	Credit Hours	40 per week
	Maximum Benefit	26 weeks

SCHEDULE OF BENEFITS – BASIC PLAN

This Schedule of Benefits applies to Covered Persons in the Basic Plan.

- The amounts charged for Covered Charges are subject to the Allowable Amount.
- The deductible applies to all Covered Charges unless specifically noted.
- Coinsurance amounts set forth below reflect the amount paid by the Plan. All other cost-sharing reflects amounts paid by the Covered Person.

COMPREHENSIVE MEDICAL BENEFITS			
	Network Provider		**Non-Network Provider**
Coinsurance	70% paid by Plan		Not covered
	Protected Services and Continuing Care Services are payable at the Network Provider rate		
Deductible per Calendar Year	$1,000/Covered Person $3,000/Family		Not covered
	Protected Services and Continuing Care Services accumulate to the Network Deductible.		
Out-of-Pocket Maximum per Calendar Year	$5,600/Covered Person $11,200/Family		Not covered
	After a Covered Person satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Charges for the remainder of the Calendar Year. Protected Services and Continuing Care Services accumulate to the Network Out-of-Pocket Maximum.		
SPECIFIC COVERAGE AMOUNTS			
Office Visits			
Primary Care Physician	$25 Copay Deductible does not apply		Not covered
Specialist	$50 Copay Deductible does not apply		Not covered
Mental Health and Substance Abuse	$25 Copay Deductible does not apply		Not covered
Telehealth Connection Services and Teladoc	100% Deductible does not apply		Not covered
Preventive Care	100% Deductible does not apply		Not covered
Breast feeding equipment and supplies	100% Deductible does not apply		Not covered
	Limited to purchase of one breast pump per birth (single or multiple) or rental of one breast pump per birth		
Outpatient Services			
Outpatient surgery	**Center of Excellence**	**Network Provider**	**Non-Network Provider**
	90%	70%	Not covered
Hearing Aid	70%		Not covered
	Maximum $2,000/ear every 5 years		
Labs	**LabCorp/Quest**	**Network Provider**	**Non-Network Provider**
	100% Deductible does not apply	70%	Not covered
Scans and Diagnostic Services	**Freestanding Facility**	**Network Provider**	**Non-Network Provider**
	$25 Copay	70%	Not covered

COMPREHENSIVE MEDICAL BENEFITS		
	Network Provider	**Non-Network Provider**
	Deductible does not apply	
	Freestanding Facility means a facility not owned by a hospital or physician group. Scans and diagnostic services includes but is not limited to: radiology, x-ray, anesthesia, pathology, CT, PET, MRI, nuclear scans. Protected Services payable at Network Provider rate.	
Physical, Speech, and Occupational Therapy	$25 Copay Deductible does not apply	Not covered
	Limited to 60 visits combined each Calendar Year.	
All other therapies, including cognitive therapy and pulmonary rehab	70%	Not covered
	Limited to 60 visits combined each Calendar Year	
DME, Orthotics and Prosthetics	70%	Not covered
	Foot orthotics maximum $1,000 per Calendar Year	
Home Health Services and Hospice	70%	Not covered
Chiropractic Care	$10 Copay Deductible does not apply	Not covered
	Limited to 40 visits each Calendar Year	
Inpatient Services		
Hospital Services	70%	Not covered
Skilled Nursing Facility, Extended Care Facility, Convalescent or Subacute Facility	70%	Not covered
	Limited to 100-day maximum cross accumulates among all benefit levels	
Mental Health and Substance Abuse Residential Care	70%	Not covered
Observation Room	70%	Not covered
Physician Hospital Visits and Specialist Care/Consultations	70%	Not covered
Other Services	70%	Not covered
	Other services include, but are not limited to, emergency room, radiology, anesthesiology, and pathology. Protected Services are payable at the Network Provider rate.	
Emergency and Urgent Care		
Hospital Emergency Room	$250 Copay then 70% paid by Plan Deductible does not apply	$250 Copay then 80% paid by Plan Deductible does not apply
	Copay waived if admitted within 24 hours of initial emergency room visit or after a period of continuous observation that is less than 72 hours; standard Deductible/coinsurance would then apply. Copay includes any continuous observation (but less than 72 hours) prior to any admission.	
Urgent Care Facility	$75 Copay Deductible does not apply	Not covered
Ambulance Services – Ground	$150 Copay Deductible does not apply	$150 Copay Deductible does not apply
Ambulance Services - Air	$1,000 Copay Deductible does not apply	$1,000 Copay Deductible does not apply

DENTAL BENEFITS			
	PPO Network	**Premier Network**	**Non-Network**
Deductible per Calendar Year	None	$50	Not covered
Preventive Services	100%	75%	Not covered

SHORT-TERM DISABILITY BENEFIT		
Short-Term Disability Benefit	**Weekly Indemnity**	$550 per week
	Maximum Benefit	26 weeks
Maternity Leave Benefit	**Weekly Indemnity**	$800 per week
	Credit Hours	40 per week
	Maximum Benefit	26 weeks

SCHEDULE OF BENEFITS – PRESCRIPTION DRUGS

This Schedule of Benefits applies to Covered Persons in the Premium and Basic Plans.

- Cost-sharing amounts set forth below reflect the amount paid by the Covered Person.
- Maintenance medications must be filled by mail order or at a pharmacy participating in the Restricted Retail Pharmacy Network for a 90-day supply or the Covered Person must pay the full cost of the drug.
- Covered Persons who fill a brand drug when a generic equivalent is available must pay the difference in the brand drug cost versus the generic cost plus the generic coinsurance.

PRESCRIPTION DRUG BENEFITS			
	Coinsurance	**Per Prescription:**	
		Minimum	**Maximum**
Generic			
30-day supply (retail or mail order)	10%	$10	$20
90-day supply (retail or mail order)	10%	$20	$40
Preferred Brand			
30-day supply (retail or mail order)	30%	$20	$75
90-day supply (retail or mail order)	30%	$40	$150
Non-Preferred Brand			
30-day supply (retail or mail order)	40%	$30	$125
90-day supply (retail or mail order)	40%	$60	$250
Diabetes and Insulin Supplies			
30-day supply	10%	$10	$50
90-day supply	10%	$20	$100
Non-Select Specialty			
Preferred Brand	35%	$40	$150
Non-Preferred Brand	40%	$40	$250
Select Specialty			
Enrolled in Specialty Pharmacy Copay Assistance Program	No charge	$0	$0
Not Enrolled in Specialty Pharmacy Copay Assistance Program	30%	N/A	N/A
Out-of-Pocket Maximum	$3,500 per Covered Person / $7,000 per family		
Coinsurance for failure to enroll in the Specialty Pharmacy Copay Assistance Program and any specialty drug coupons do not count toward the out-of-pocket maximum.			

SCHEDULE OF BENEFITS – LIFE AND AD&D

This Schedule of Benefits applies to Covered Persons in the Premium and Basic Plans.

- Benefits are fully insured by the Contracted Provider.
- The insurance contract will control in the event of any discrepancy between this schedule and the policy.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)		
Life Insurance	Benefit Until 7/31/2025	Benefit Effective 8/1/2025
Participant	$8,000	$50,000
Pre-65 Retiree	$8,000	$25,000
Dependent	$2,000	$2,500
AD&D	Benefit	
Life	$8,000	
One hand, one foot or sight of one eye	$4,000	
Both hands, both fee, sight of both eyes or any combination of two or more of the above losses	$8,000	

SCHEDULE OF BENEFITS – ST. LOUIS WELLNESS CENTER

This Schedule of Benefits applies to all Covered Persons eligible for the Carpenters Wellness Center.

- Cost-sharing amounts set forth below reflect the amount paid by the Covered Person.
- Deductible does not apply to Carpenters Wellness Center services.

CARPENTERS WELLNESS CENTER – ST. LOUIS	
Medical	**Covered Person Pays**
Scheduled Provider Visits	$0
➢ Includes: preventive care, condition management, procedures, chiropractic services, medical massage therapy (wellness center provider referral only), physical therapy, coaching, counseling, audiology	
Durable Medical Equipment	$0
➢ Includes, but not limited to, crutches, braces, splints and boots	
Hearing Exams	$0
Hearing Aid (Participants only; one per ear every 5 years)	$150 per aid
Internal Lab and/or X-Ray Orders (ordered by Wellness Center Providers)	$0
Outside Lab and/or X-Ray Orders (ordered by outside providers for Covered Person who is not a primary care patient at the Wellness Center)	$20
Fees for No Shows	$20
Pharmacy	
All Formulary Medication Prescriptions	$0
Non-Formulary Medication Prescriptions	Full Cost of Medication
Dental	Refer to applicable Dental Schedule in D-XI or D-XII
Vision	
Comprehensive Eye Exam	$0
Pre-Testing and Retinal Imaging	$0
Frames (every 24 months)	20% of the balance after Plan pays $150 or $170 for brand name frames
Lenses (every calendar year)	$0
Lens Enhancements (every calendar year)	
➢ Standard Progressive	Balance after Plan pays $50
➢ Premium Progressive	Balance after Plan pays $80-$90
➢ Custom Progressive	Balance after Plan pays $120-$160
Contacts instead of glasses (every calendar year)	$0
Contacts, elective (every calendar year)	Balance after Plan pays $150
Safety Frames (Participants only, every 24 months)	$25

SCHEDULE OF BENEFITS – KANSAS CITY WELLNESS CENTER

This Schedule of Benefits applies to all Covered Persons eligible for the Carpenters Wellness Center.

- Cost-sharing amounts set forth below reflect the amount paid by the Covered Person.
- Deductible does not apply to Carpenters Wellness Center services.

CARPENTERS WELLNESS CENTER – KANSAS CITY	
Medical	**Covered Person Pays**
Scheduled Provider Visits	$0
➢ Includes: preventive care, condition management, procedures, chiropractic services, counseling	
Durable Medical Equipment	$0
➢ Includes, but not limited to, crutches, braces, splints and boots	
Internal Lab and/or X-Ray Orders (ordered by Wellness Center Providers)	$0
Pharmacy	
Limited Formulary Medication Prescriptions	$0