RESOLUTION AMENDING THE
CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND PLAN DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Chicago Regional Council of Carpenters Welfare Fund:

WHEREAS, Article XVII, section 17.01 of the Chicago Regional Council of Carpenters Welfare Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan to provide 100% coverage for qualifying COVID-19 preventive services recommended by the U.S. Preventive Services Task Force with an "A" or "B" rating, or by the Advisory Council on Immunization Practices and adopted by the Centers for Disease Control and Prevention, including administration of such services, consistent with the requirements of the Coronavirus Aid, Relief, and Economic Security Act and corresponding regulatory guidance, effective as of December 14, 2020; and

WHEREAS, the Trustees further desire to amend the Plan effective February 17, 2021, to temporarily extend eligibility for Active Plan Employees who were covered for the March 1, 2020 Coverage Quarter but would otherwise lose eligibility for the March 1, 2021 Coverage Quarter due to a reduction of hours.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned acknowledge and affirm that the Trustees at their February 17, 2021 meeting took action to amend the Plan by adopting Amendment No. 1, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Jr. Chairman — Date: 2-18-21

Gerald W. Thiel, Jr., Secretary — Date: 2/22/2021

EXHIBIT A

AMENDMENT NO. 1 TO THE CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND PLAN DOCUMENT (RESTATED EFFECTIVE DECEMBER 1, 2020)

The Chicago Regional Council of Carpenters Welfare Fund Plan Document Plan is hereby amended as follows:

1. Effective December 14, 2020, Article XIX, COVID-19 Temporary Relief, Section 19.01, COVID-19 Plan Coverage, is amended to add a new subsection (C) to read as follows:

   (C) Until the end of the COVID-19 Public Health Emergency, the Plan will provide one hundred percent (100%) coverage for qualifying COVID-19 related preventive services with an "A" or "B" rating from the U.S. Preventive Services Task Force, or that have in effect a recommendation from the Advisory Committee on Immunization Practices that the Centers for Disease Control and Prevention has adopted, and corresponding administration as follows:

   (1) Provided by a Contracted Provider under the Prescription Drug benefit, Article VIII; and

   (2) Provided by an Out-of-Network provider. If the primary purpose of an office visit is to obtain a qualifying COVID-19 preventive service, the office visit will also be covered without cost sharing. The Plan shall reimburse the Out-of-Network provider for such service in an amount that is reasonable, as determined in comparison to prevailing market rates for such service. Such qualifying COVID-19 preventive care shall be available under the Wellness Care benefit, section 5.04(PP), and the Prescription Drug benefit, Article VIII.

2. Effective February 17, 2021, Article XIX, COVID-19 Temporary Relief, Section 19.02, Temporary Eligibility Extension, is amended to add a new subsection (D) to read as follows:

   (D) Effective for the March 1, 2021 Coverage Quarter, eligibility is temporarily extended for active Employees who were covered for the March 1, 2020 Coverage Quarter but who would otherwise lose eligibility for the March 1, 2021 Coverage Quarter due to a reduction of hours. In addition to the Participants excluded under section 19.02(A), the March 1, 2021 Coverage Quarter extension excludes: Participants whose last hours were not paid by a Contributing Employer for work performed in 2020 (e.g., Short Term Disability hours credited under Plan Section 10.01); Retirees in pay status as of March 1, 2021; Employees participating under a Collective Bargaining Agreement or Participation Agreement establishing month-to-month eligibility; Employees of the Fund Office or Council whose employment terminated in 2019 or 2020; and deceased Participants.

RESOLUTION AMENDING THE
CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND PLAN DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Chicago Regional Council of Carpenters Welfare Fund:

WHEREAS, Article XVII, section 17.01 of the Chicago Regional Council of Carpenters Welfare Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan to provide coverage for in-patient Hospital care beyond 180 days when deemed Medically Necessary, effective as of January 1, 2019;

WHEREAS, the Trustees desire to amend the Plan effective April 1, 2020 to clarify the temporary reduction of monthly COBRA premiums applicable to the Active Plan;

WHEREAS, the Trustees desire to amend the Plan effective April 1, 2021, to remove the exclusion for couples' therapy (formerly known as marital counseling); and

WHEREAS, the Trustees desire to amend the Plan effective May 19, 2021, to clarify acceptable documentation for proof of Dependent status.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned acknowledge and affirm that the Trustees at their May 19, 2021 meeting took action to amend the Plan by adopting Amendment No. 2, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Jr. Chairman — 5/24/2021 Date

Gerald W. Thiel, Jr., Secretary — 5/21/2021 Date

EXHIBIT A

AMENDMENT NO. 2 TO THE CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND PLAN DOCUMENT (RESTATED EFFECTIVE DECEMBER 1, 2020)

The Chicago Regional Council of Carpenters Welfare Fund Plan Document is hereby amended as follows:

1. Effective April 1, 2021, Article XIII, Plan Exclusions and Limitations, Section 13.01(U), is amended to read as follows:

> (U) Charges for bereavement counseling, pastoral counseling, financial or legal counseling, and funeral arrangements except to the extent covered by the MAP as described in Plan Section 5.04(X).

2. Effective May 22, 2021, Article III, Eligibility, Section 3.16, subsection (G)(1), is amended to read as follows:

> (1) The Participant must submit proof of Dependent status in the form of a county certified marriage certificate as may be requested by the Plan for determining the marriage date, county certified birth certificate and, if necessary, additional information or proof as requested by the Plan for identifying the names of the parents (such as a paternity test document that lists the Participant as one of the biological parents), Qualified Medical Child Support Order or a National Medical Support Notice, Interim Order of Placement and/or the Final Adoption Order identifying the Participant as the child's parent. Hospital or church certificates are not acceptable documentation. A voluntary acknowledgment of paternity will not be accepted as proof of paternity;

3. Effective April 1, 2020, Article XIX, COVID-19 Temporary Relief, Section 19.04 is amended and restated to read as follows:

> **Section 19.04 Temporary Reduction of Monthly COBRA and Low Cost Premiums for the Active Plan**
>
> Monthly COBRA and Low Cost premiums for the Active Plan will be reduced by twenty-five percent (25%) for the coverage months of April 2020 through March 31, 2021.

4. Effective January 1, 2019, Appendix A, Schedule of Benefits for the Active Plan of Benefits, is amended to provide coverage for in-patient Hospital care beyond 180 days when deemed Medically Necessary.

5. Effective January 1, 2019, Appendix B, Schedule of Benefits for the Retiree Plan of Benefits, is amended to provide coverage for in-patient Hospital care beyond 180 days when deemed Medically Necessary. Amended Appendix B, attached hereto, reflects the above-referenced Amendment.

6. Effective January 1, 2019, Appendix C, Schedule of Benefits for the Low Cost Medical Plan of Benefits is amended to provide coverage for in-patient Hospital care beyond 180 days when deemed Medically Necessary.

Appendix A

SCHEDULE OF BENEFITS
FOR THE ACTIVE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Active Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per Covered Individual $900 per family	$600 per Covered Individual $1,800 per family
Out-of-Pocket Maximum per Calendar Year	$2,300 per Covered Individual $6,900 per family (includes Calendar Year Deductible)	$6,000 per Covered Individual $18,000 per family (Does not include Calendar Year Deductible)
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care,* page App A-2	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	80% paid by Plan	60% paid by Plan
	Prior to surgery, a Covered Individual is required to contact the Fund Office to enroll in and successfully complete ComPsych's Bariatric Support Service Program (BSSP). Participation in the BSSP is mandatory for coverage.	
• **Behavioral Health Care**	See page App. A-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation support and counseling o Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care** (Combined Benefit)	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
	See Plan Sections 5.04(H)	
• **Contraceptives**, including related office visits, to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	80% paid by Plan	60% paid by Plan
	Annual Dental Benefit must be exhausted	

	Absolute Solutions Network	BCBS PPO Provider	Out-of-Network Provider
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	100% paid by Plan (Calendar Year Deductible does not apply)	80% paid by Plan	60% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room** o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

<table>
<tr><th></th><th>BCBS PPO Provider</th><th>Out-of-Network Provider</th></tr>
<tr><td>• Hearing Benefit</td><td></td><td></td></tr>
<tr><td>o Hearing evaluation/exam for a newborn (ages 0 to 31 days) as required under the Affordable Care Act</td><td>100% paid by Plan.
Calendar Year Deductible does not apply</td><td>80% paid by Plan
Calendar Year Deductible does not apply</td></tr>
<tr><td>o Hearing evaluation/exam</td><td>Paid at 100% per Covered Individual once every two (2) consecutive Calendar Years.
Calendar Year Deductible does not apply</td><td>No coverage</td></tr>
<tr><td>o Hearing aid instrument</td><td>Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)</td><td>BCBS PPO Provider</td><td>Out-of-Network Provider</td></tr>
<tr><td>➢ Dependent children through age 18</td><td colspan="2">Paid at 100% up to $2,500 maximum per Covered Individual once every three (3) consecutive Calendar Years
Calendar Year Deductible does not apply</td></tr>
<tr><td>➢ Participant, spouse and Dependent children age 19 and older</td><td colspan="2">Paid at 100% up to $2,500 maximum per Covered Individual once every five (5) consecutive Calendar Years
Calendar Year Deductible does not apply</td></tr>
<tr><th></th><th>BCBS PPO Provider</th><th>Out-of-Network Provider</th></tr>
<tr><td rowspan="2">• Home Health Care</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Maximum of 120 visits per year</td></tr>
<tr><td rowspan="2">• Hospice Care</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Lifetime maximum of 180 days per Covered Individual</td></tr>
<tr><td rowspan="2">• Hospital Care</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days</td></tr>
<tr><td rowspan="2">• Infertility Services including Hospital, Physician, prescription drugs & treatments. except diagnostic genetic testing which may be covered above</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">Combined lifetime maximum of $10,000 for services provided to the Employee and spouse.
No coverage for dependent children.</td></tr>
<tr><td>• Infusion Therapy for the administration of an intravenous prescription drug</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Member Assistance Program</td><td colspan="2">See page App. A-5</td></tr>
<tr><td>• Naprapathic Care</td><td colspan="2">See Chiropractic, Acupuncture and Naprapathic Care, page App A-2</td></tr>
<tr><td>• Nutritional Counseling to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders</td><td>100% paid by Plan
Calendar Year Deductible does not apply</td><td>No coverage</td></tr>
<tr><td>• Oral and Maxillofacial Surgery</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Organ Transplant</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Physician Services</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Pregnancy Care</td><td>80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.</td><td>60% paid by Plan</td></tr>
<tr><td rowspan="2">• Prosthetics
o Artificial limbs and eyes
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="2">100% paid by Plan, subject to a $500 lifetime maximum.
Calendar Year Deductible does not apply</td></tr>
<tr><td>• Reconstructive Breast Surgery</td><td>80% paid by Plan</td><td>60% paid by Plan</td></tr>
</table>

	BCBS PPO Provider	Out-of-Network Provider
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See page App. A-5	
• **Surgi-Center Facility** o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
Therapy Services • **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50-visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar year	
- (For additional benefits beyond the 50-visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• Premium Lens replacements in conjunction with cataract surgery	$1,000 maximum per lens (maximum two lenses per lifetime)	$1,000 maximum per lens (maximum two lenses per lifetime)
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations, and other services (see **www.healthcare.gov** for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose, and cholesterol analysis, strength, and flexibility testing, mammogram, or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for five short-term counseling sessions per issue Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out-of-Network Provider**
• **Emergency Room** o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room Visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days	
• **Hospital Outpatient Diagnostic Tests**	80% paid by Plan	60% paid by Plan
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

VISION CARE BENEFITS Contracted Network Provider: Vision Service Plan of Illinois (VSP) Vision coverage is provided by the contracted provider and is described in the insurance policy issued by the contracted provider. Vision coverage includes, but is not limited to:		
	VSP In-Network Provider (Participant's Cost)	**Out-of-Network Provider (Maximum Amount Plan Pays)**
Frequency • **Exam** • **Lenses or contacts** • **Frame**	Once per Calendar Year	
Exam Co-payment	$0 Co-pay	Up to $45
Frame Allowance • Frames up to $200 ($220 for VSP featured frame brands)	$0 Co-pay* *20% savings on amounts above allowance	Up to $70
Lenses • Single vision • Bifocal lined • Trifocal lined • Standard progressive lens • Premium progressive lens • Custom progressive lens	 $0 Co-pay $0 Co-pay $0 Co-pay $0 Co-pay $95-$105 Co-Pay 150-$175 Co-pay	 Up to $30 Up to $50 Up to $65 Up to $50 Up to $50 Up to $50
Contacts (in lieu of Glasses) • $125 allowance for contacts • Contact lens exam (fitting and evaluation)	$0 Co-pay $40	Up to $105
Safety Glasses (Employees Only) • **Safety Frame** from the ProTec Eyewear Collection • **Lenses –** Prescription single vision, lined bifocal, and lined trifocal. Polycarbonate and Progressives covered in full	$10 Co-Pay for frame and lenses	No coverage

DENTAL BENEFITS

Contracted Network Provider: Delta Dental of Illinois

Dental benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Annual Maximum	$2,500		
Annual Deductible (applies only to Basic and Major Care)	$50/person / $100/family		
Balance Billing (the difference between the dentist's actual charge and the amount allowed by Delta Dental.)	Does not apply	Does not apply	Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance
• **Preventive/Diagnostic Care (1)**			
o Covered Individual through age 18	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum
o Covered Individual - age 19 and older	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum
• **Basic Care (2)** (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Major Care (3)** (all ages**)**	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Orthodontia (4)**	Effective January 1, 2020, when services are rendered by a Delta Dental provider, the orthodontia charges are paid at 80% subject to a lifetime maximum of $5,000.		Paid at 80% of the Dentist's usual fee subject to a lifetime maximum of $2,000

(1) Preventive/Diagnostic Care includes:

- ✓ Oral evaluations (two in 12-month period)
- ✓ Prophylaxis/Cleaning (two in a 12-month period)
- ✓ X-rays (bitewings two in a 12-month period; full mouth or panoramic once in 36-month period; cephalometric once in a 24 month period)
- ✓ Fluoride Treatment (once in a 12-month period for Dependent children through age 18)
- ✓ Palliative Treatment
- ✓ Sealants (once per lifetime on 1st and 2nd molars only, for Dependent children through age 14)

(2) Basic Care includes:

- ✓ Fillings
- ✓ Oral Surgery
- ✓ General Anesthesia
- ✓ Periodontics
- ✓ Endodontics
- ✓ Consultations
- ✓ Removal of cysts & tumors in the mouth
- ✓ Space Maintainers (5-year interval for Dependent children up to age 13)

(3) Major Care includes (services are covered once in a 5-year period) include:	
✓ Crowns, Jackets & Case Restoration	✓ Veneers (Permanent Teeth Only)
✓ Fixed & Removable Bridges	✓ Implants and related services
✓ Partial & Full Dentures	

Note: All Frequency limitations listed above are to the day.

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and

Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	ESI Network Retail Pharmacy (Lesser of 100 units or a 30-day supply)	**ESI By Mail** (Up to a 90-day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Select Specialty Medications	Does not apply		See Plan Sections 8.01(D) and 8.02.

SHORT TERM DISABILITY BENEFITS

(For Employees Only)

Non-Occupational (Not work-related)	Weekly benefits include a payment up to $450 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational (Work-related)	Weekly benefits include credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.

LIFE INSURANCE BENEFITS

Contracted Provider: Aetna Life Insurance Company

	Eligible Participant	**Spouse**	**Child**
Policy amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS FOR ELIGIBLE EMPLOYEES ONLY Contracted Provider: Aetna Life Insurance Company				
Type of Loss	**Benefit Amount**		**Type of Loss**	**Benefit Amount**
Life	$50,000		Both feet	$50,000
One hand and one foot	$50,000		Both hands	$50,000
One foot and sight of one eye	$50,000		Sight of one eye	$25,000
One hand and sight of one eye	$50,000		One foot	$25,000
Sight of both eyes	$50,000		One hand	$25,000
Speech and hearing in both ears	$50,000		Thumb and index finger	$12,500

Appendix B

SCHEDULE OF BENEFITS
FOR THE RETIREE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Retiree Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per Covered Individual $600 per family	$600 per Covered Individual
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family (includes deductible)	$6,000 per Covered Individual
	After a Covered Individual satisfies the deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO deductibles and Out-of-Pocket Maximums are separate and cannot be combined	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit), see page App B-2*	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	80% paid by Plan	60% paid by Plan
	A Covered Individual is required to contact BCBSIL before any treatment is given and must be approved for surgery.	
• **Behavioral Health Care**	See page App. B-5	
• **Breast Feeding Support and Equipment** as required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
• **Contraceptives,** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	80% paid by Plan	60% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room** o Facility o Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

<table>
<tr><th></th><th colspan="2">BCBS PPO Provider</th><th>Out-of-Network Provider</th></tr>
<tr><td>• Hearing Benefit
o Hearing evaluation/exam</td><td colspan="3">Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)</td></tr>
<tr><td>oHearing aid instrument</td><td>Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)</td><td>BCBS PPO Provider</td><td>Out-of-Network Provider</td></tr>
<tr><td>➢ Dependent children through age 18</td><td colspan="3">Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply</td></tr>
<tr><td>➢ Participant, spouse, and Dependent children age 19 and older</td><td colspan="3">Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply</td></tr>
<tr><th></th><th colspan="2">BCBS PPO Provider</th><th>Out-of-Network Provider</th></tr>
<tr><td rowspan="2">• Home Health Care</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Maximum of 120 days per convalescent period</td></tr>
<tr><td rowspan="2">• Hospice Care</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Lifetime maximum of 180 days per individual</td></tr>
<tr><td rowspan="2">• Hospital Care</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.</td></tr>
<tr><td rowspan="2">• Infertility Services including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing, which may be covered above</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse.
No coverage for dependent children.</td></tr>
<tr><td>• Infusion Therapy for the administration of an intravenous prescription drug</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Naprapathic Care</td><td colspan="3">See Chiropractic, Acupuncture and Naprapathic Care, page App B-2</td></tr>
<tr><td>• Nutritional Counseling to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders</td><td colspan="2">100% paid by Plan
Calendar Year Deductible does not apply</td><td>No Coverage</td></tr>
<tr><td>• Oral and Maxillofacial Surgery</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Organ Transplant</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Physician Services</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Pregnancy Care</td><td colspan="2">80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.</td><td>60% paid by Plan</td></tr>
<tr><td rowspan="2">• Prosthetics
o Artificial limbs and eyes
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">100% paid by Plan, subject to a $500 lifetime maximum
Calendar Year Deductible does not apply</td></tr>
<tr><td>• Reconstructive Breast Surgery</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
</table>

	BCBS In-Network Provider	Out-of-Network Provider
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan, Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See Page App. B-5	
• **Surgi-Center Facility** o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services** o **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50-visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50-visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act, including routine screenings, immunizations, and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose, and cholesterol analysis, strength, and flexibility testing, mammogram, or prostate screening and more	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Covered Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE	
• **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS In-Network Provider	**Out-of-Network Provider**
• **Emergency Room** o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours. Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement Maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN HOSPITAL BENEFITS ONLY AS DESCRIBED IN PLAN SECTION. 5.04(U) **Per Benefit Period*** ***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.** Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)	
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)**	**Plan Pays secondary to Medicare** **Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible
o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 days	Plan pays 100% of Medicare eligible expenses

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS Per Benefit Period*

***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.**

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit) ***	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible
o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 Days	Plan Pays 100% of Medicare eligible expenses
• **Medicare Part B Supplement**	
o Medicare Part B Deductible	Plan pays Medicare Part B Deductible
o Medical expenses	Plan pays 20% of Medicare eligible expenses at the Medicare approved amount, after the Medicare Part B Deductible
• **Blood**	Plan pays for three (3) pints
• **Skilled Nursing Facility Care*** - Covered Individual must meet Medicare's requirements, including having been in a Hospital for at least three days and enter a Medicare approved facility within 30 days of leaving the Hospital	
o First 20 days	Medicare pays all approved amounts
o 21st through 100th day	Plan pays Medicare Part A Co-Payment
• **At Home Recovery Services Not Covered by Medicare** – Home care certified by a Covered Individual's Doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home treatment plan.	
o Benefit for each visit	Plan pays up to $40 per visit Up to a Calendar Year Maximum of $1,600
• **Foreign Travel**	
o Calendar Year Deductible	$250 per Covered Individual
	Plan pays 80%. The Plan does not pay for expenses in excess of the Reasonable and Customary Allowance for non-PPO Out-of-Network providers. Amounts over the Reasonable and Customary Allowance are the Covered Individual's responsibility
o Lifetime Maximum for Foreign Travel	$50,000

• **Hearing Benefit** o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
oHearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply		
➢ Participant, spouse, and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply		

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

PRESCRIPTION BENEFIT

Contracted Network Provider: Express Scripts, Inc. (ESI) and Accredo Specialty Pharmacy

Not available to Deferred Lathers or to Medicare-eligible individuals with Medicare Part D coverage.

	ESI Network Retail Pharmacy (Lesser of 100 pills or a 30-day supply)	**ESI by Mail** (Up to a 90-day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Single-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Non-Select Specialty Medication Out-of-Pocket Maximum per Calendar Year	Does not apply		$1,500 per individual / $3,000 per family
Select Specialty Medications (Co-payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.04.

INSURED BENEFITS	CARRIER
• Dental Benefits	Delta Dental of Illinois
• Vision Benefits	Vision Service Plan of Illinois (VSP)
• Life Insurance Benefit ($25,000, Retirees Under Age 65 Only)	The Hartford

Appendix C

SCHEDULE OF BENEFITS
FOR THE LOW COST MEDICAL PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Low Cost Medical Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	70% paid by Plan	50% paid by Plan
Deductible per Calendar Year	$600 per Covered Individual / $1,800 per family	
Out-of-Pocket Maximum per Calendar Year	$4,600 per Covered Individual / $9,200 per family (includes Deductible)	
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible covered services for the remainder of the Calendar Year.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care, page App C-2*	
• **Ambulance Service**	70% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	70% paid by Plan	50% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	70% paid by Plan	50% paid by Plan
	Prior to surgery, a Covered Individual is required to contact the Fund Office to enroll in and successfully complete ComPsych's Bariatric Support Service Program (BSSP). Participation in the BSSP is mandatory for coverage.	
• **Behavioral Health Care**	See page App. C-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	70% paid by Plan	50% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year. No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	70% paid by Plan	50% paid by Plan
	See Plan Section 5.04(H)	
• **Contraceptives** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	70% paid by Plan	50% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	70% paid by Plan	50% paid by Plan
• **Durable Medical Equipment**	70% paid by Plan	50% paid by Plan
• **Emergency Room**	70% paid by Plan	70% paid by Plan
o Facility fees o Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	70% paid by Plan	50% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	50% paid by Plan Subject to Calendar Year Deductible, Subject to Out-of-Pocket Maximums and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	70% paid by Plan	50% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage
• **Hearing Benefit**	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
• **Home Health Care**	70% paid by Plan	50% paid by Plan
	Maximum of 120 visits per year	

	BCBS PPO Provider	Out-of-Network Provider
• **Hospice Care**	70% paid by Plan	50% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
• **Hospital Care**	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing which may be covered above	70% paid by Plan	50% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	70% paid by Plan	50% paid by Plan
• **Member Assistance Program**	See page App. C-5	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App C-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
• **Oral and Maxillofacial Surgery**	70% paid by Plan	50% paid by Plan
• **Organ Transplant**	70% paid by Plan	50% paid by Plan
• **Physician Services**	70% paid by Plan	50% paid by Plan
• **Pregnancy Care**	70% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Deductible does not apply.	50% paid by Plan
• **Prosthetics** o Artificial limbs and eyes	70% paid by Plan	50% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	No coverage	
• **Reconstructive Breast Surgery**	70% paid by Plan	50% paid by Plan
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No Coverage
o Males	70% paid by Plan	No Coverage
o Sterilization reversals (female/male)	No Coverage	No Coverage
• **Substance Use Disorder**	See page App. C-5	
• **Surgi-Center Facility** o Hospital Affiliated	70% paid by Plan	50% paid by Plan
o No Hospital Affiliation	70% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	70% paid by Plan	50% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	70% paid by Plan	50% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	70% paid by Plan	50% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	70% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services** o **Physical and Speech Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50-visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
o **Occupational Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50-visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
o **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	70% paid by Plan	50% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	70% paid by Plan	50% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	70% paid by Plan	50% paid by Plan
• **Wellness and Preventive Care** o **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations, and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose, and cholesterol analysis, strength, and flexibility testing, mammogram, or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Participant and spouse once every Calendar Year. Calendar Year Deductible does not apply. No coverage for Dependent children	

HEALTH CENTER For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out of Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for 5 short-term counseling sessions per issue. Calendar Year Deductible does not apply.	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out of Network Provider**
• **Emergency Room** o Facility	70% paid by Plan	70% paid by Plan
o Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	70% paid by Plan	50% Paid by Plan
	Confinement maximum: 180 days per calendar year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Hospital Outpatient Diagnostic Tests**	70% paid by Plan	50% paid by Plan
• **Outpatient Therapy** (Including Partial Hospitalization)	70% paid by Plan	50% paid by Plan
• **Custodial or Group Homes**	No coverage	

RESOLUTION AMENDING THE
CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND PLAN DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Chicago Regional Council of Carpenters Welfare Fund:

WHEREAS, Article XVII, section 17.01 of the Chicago Regional Council of Carpenters Welfare Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2021 to clarify coverage for disabled Dependents; and

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2021 to clarify the eligibility rules;

NOW, THEREFORE, BE IT RESOLVED, that the undersigned acknowledge and affirm that the Trustees at their August 18, 2021 meeting took action to amend the Plan by adopting Amendment No. 3, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — 8/18/2021 Date

Gerald W. Thiel, Jr., Secretary — 8/18/2021 Date

EXHIBIT A

AMENDMENT NO. 3 TO THE CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND PLAN DOCUMENT (RESTATED EFFECTIVE DECEMBER 1, 2020)

The Chicago Regional Council of Carpenters Welfare Fund Plan Document is hereby amended as follows:

1. Effective January 1, 2021, Article II, Definitions, Section 2.30(D)(2) is amended to read as follows:

> (2) The disability is considered permanent and began prior to the child attaining age twenty-six (26) while the child was covered as a Dependent under this Plan, unless the disability began at birth and the Dependent was covered under this Plan for at least five (5) consecutive years prior to the Dependent turning age 26, and proof of such is provided to the Fund Office.

2. Effective January 1, 2021, Article II, Definitions, Section 2.3(E)(2) is amended to read as follows:

> (2) The disability is considered permanent and began prior to the stepchild attaining age twenty-six (26), while the stepchild was covered as a Dependent under this Plan, unless the disability began at birth and the Dependent was covered under this Plan for at least five (5) consecutive years prior to the Dependent turning age 26, and proof of such is provided to the Fund Office.

3. Effective January 1, 2021, Article II, Definitions, is amended to add a new Section 2.36, Eligibility Service, to read as follows. All subsequent sections are renumbered accordingly.

> "Eligibility Service" shall equal all vesting credit and service credit (as defined in a Pension Plan) that a participant earned under a Pension Fund; provided, however, that such vesting credit and service credit shall only be considered "Eligibility Service" to the extent it was earned while the Participant was working for an Employer whose Collective Bargaining Agreement required Contributions to one of the Pension Funds and to this Fund except for vesting credit or service credit earned:
>
> (A) prior to June 1975, under the Chicago Regional Council of Carpenters Pension Fund or the Chicago Regional Council of Carpenters Millmen Pension Fund (including pension credit earned under the Millmen Pension Fund prior to June 1975),
>
> (B) prior to March 1, 2003 under the Carpenters Pension Fund of Illinois,
>
> (C) prior to January 1, 2019 under the Will County Local 174 Pension Fund, or

(D) as a result of Military Service or while receiving Short Term Disability Benefits under this Plan.

4. Effective January 1, 2021, Article III, Eligibility, is amended to update references to the Plan's definition of Eligibility Service. The following sections are amended accordingly.

Section 3.03, subsection (A)(1), is amended to read:

(1) Is receiving pension benefits from the Chicago Regional Council of Carpenters Pension Fund or the Chicago Regional Council of Carpenters Millmen Pension Fund based on at least ten (10) years of Eligibility Service. If at some time the Participant did not earn Eligibility Service for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of Eligibility Service.

Section 3.03, subsection (A)(2), is amended to read:

(2) Commenced receiving pension benefits from the Carpenters Pension Fund of Illinois as a member of Local Union Nos. 363, 916 or 2087 on or after March 1, 2003 based on at least ten (10) years of Eligibility Service. If at some time the Participant did not earn Eligibility Service for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of Eligibility Service;

Section 3.03, subsection (A)(5), is amended to read:

(5) Commenced receiving pension benefits from the Will County Local 174 Carpenters Pension Fund on or after January 1, 2019 with a pension based on at least ten (10) years of Eligibility Service. If at some time the Participant did not earn Eligibility Service for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of Eligibility Service. For purposes of this Plan Section 3.03(A)(5) and Plan Section 3.07, Eligibility Service shall include:

(a) The total years of past service credit earned prior to June 1, 1961 by Employees under the Will County Local 174 Carpenters Pension Plan, will be counted as Eligibility Service.

(b) Hours of service earned on or after June 1, 1961 by Employees under the Will County Local 174 Carpenters Pension Fund within a Plan Year, as defined by the Will County Local 174 Carpenters Pension Plan, will be counted as Eligibility Service in the following manner:

Hours of Service under the Will County Local 174 Carpenters Pension Fund within a Plan Year	Fractional Years of Eligibility Service
Less than 250	Zero
250 but less than 500	.25 year
500 but less than 750	.50 year
750 but less than 1,000	.75 year
1,000 or more	1.00 year

(c) Years of Eligibility Service, as determined by the above chart, will be considered to have been earned during the Calendar Year in which the Plan Year of the Will County Local 174 Carpenters Pension Fund ended.

Section 3.03(B) is amended to read:

(B) If a Participant earned Eligibility Service under more than one of the Pension Funds and has commenced receiving pension benefits from each of the Pension Funds in which credit was earned, the combined Eligibility Service shall be considered when determining eligibility for benefits. However, not more than one year of combined Eligibility Service shall be counted in any Calendar Year.

Section 3.06(D) is amended to read:

(D) If a Retiree does not satisfy the eligibility requirements for the Retiree Plan as set forth in Plan Section 3.03 at the time of pension commencement, but subsequently earns additional Eligibility Service, and subsequently satisfies the eligibility requirements for the Retiree Plan, the Retiree and his Dependents will become initially eligible for the Retiree Plan on the first day of the Calendar Year following the month in which the eligibility requirements are satisfied.

Section 3.07, subsection (A)(5) is amended to read:

(5) Each Covered Individual will have their premiums determined on a tiered basis, with premium amounts determined by the years of Eligibility Service that a Participant earned with the Chicago Regional Council of Carpenters Pension Fund; Chicago Regional Council of Carpenters Millmen Pension Fund; or the Carpenters Pension Fund of Illinois; or by the years of Eligibility Service as determined in accordance with Plan Section 3.03(A)(5) under the Will County Local 174 Carpenters Pension Fund. Surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) will have the same premium rate tier as the deceased Participant.

Section 3.07, subsection (A)(6), is amended to read:

(6) If a Covered Individual meets the eligibility requirements of Plan Section 3.03(A)(3) but has less than ten (10) years of Eligibility Service, then each Covered Individual will have their premiums determined as if ten (10) years of Eligibility Service had been earned by the Participant. Similarly, if a Covered Individual meets the eligibility requirements of Plan Section 3.03(A)(4) and becomes subject to the tiered premium arrangement but has less than ten (10) years of Eligibility Service, as described in Plan Section 3.03(A)(5), then each Covered Individual will have their premium determined as if ten (10) years of Eligibility had been earned by the Participant. Surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) will have the same premium rate tier as the deceased Participant.

Section 3.07, subsection (A)(7), is amended to read:

(7) If a Participant earned Eligibility Service under more than one of the Pension Funds and has commenced receiving pension benefits from each of the Pension Funds in which Eligibility Service was earned, the combined Eligibility Service shall be considered when determining the tier level for premium amounts. However, not more than one (1) year of combined credit shall be counted in any Calendar Year.

Section 3.07, subsection (A)(8), is amended to read:

(8) The monthly medical and prescription premium rate for spouses and Dependent children (who are not yet Medicare-eligible) of pensioners receiving disability pensions is not based on the years of Eligibility Service, but is reduced and set by the Board of Trustees from time to time; however, surviving spouses (and any surviving Dependents) of pensioners receiving disability pensions who satisfy the eligibility criteria in Plan Section 3.03(C) will have their premium for coverage following the pensioner's death based on the tiered premium established pursuant to Plan Sections 3.07(A)(5) and (6) rather than this Plan Section 3.07(A)(8).

Section 3.07, subsection (A)(9), is amended to read:

(9) If a Retiree subsequently earns additional Eligibility Service and if the additional Eligibility Service changes the premium tier level for medical and prescription coverage, the Retiree will be subject to the new tier level on the first day of the Calendar Year following the Calendar Year in which the additional Eligibility Service is earned.

RESOLUTION AMENDING THE
CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND PLAN DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Chicago Regional Council of Carpenters Welfare Fund:

WHEREAS, Article XVII, section 17.01 of the Chicago Regional Council of Carpenters Welfare Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan effective October 1, 2021, to provide coverage for food supplements orally for Participants and Dependents with the diagnosis of eosinophilic gastroenteritis;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to change the name of the Fund to "Mid-America Carpenters Regional Council Health Fund";

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to add a Wellbeing Management Program to implement prior authorization and various utilization review measures;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to allow for up to twelve short-term counseling sessions per issue under the MAP and to expand the MAP to the retiree programs;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to expand the Chiropractic, Acupuncture and Naprapathic Care Benefits to cover Dependent children ages twelve and older up to a maximum of 15 visits per year;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to remove the requirement for Participants to submit Qualifying Medical Expenses to the Plan before submitting to the Health Reimbursement Account (HRA) Program;

WHEREAS, the Trustees desire to amend the Plan effective March 1, 2022, to eliminate Short Term Disability Benefits coverage for Employees exposed to COVID-19 or who had a member of their household diagnosed with COVID-19;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to reflect that the Active Plan's Behavioral Health provider has changed from ComPsych to BlueCross BlueShield of Illinois ("BCBSIL");

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to reflect that the Plan's Member Assistance Program ("MAP") provider has changed from ComPsych to Lyra Health;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to add MAP benefits to the Retiree Plan;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to eliminate the Bariatric Surgery preauthorization program that ComPsych administered;

WHEREAS, the Trustees desire to amend the Plan effective January 1, 2022, to increase the Hearing Aid Benefit maximum for the Active Plan of Benefits to $5,000 every three years for Dependent children through age eighteen, and the Active Plan of Benefits to $5,000 every five years for Participants and Dependents age nineteen and older;

WHEREAS, the Trustees desire to amend the Plan effective July 1, 2022, to increase the weekly Short Term Disability Benefit payment maximum to $550; and

WHEREAS, the Trustees desire to amend the Active Plan effective July 1, 2022, to increase the Infertility Services Benefit Maximum to $60,000 per lifetime;

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 4, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — Date: 2/16/22

Gerald W. Thiel, Jr., Secretary — Date: 2/16/22

EXHIBIT A

AMENDMENT NO. 4 TO THE
CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND PLAN DOCUMENT
(RESTATED EFFECTIVE DECEMBER 1, 2020)

The Chicago Regional Council of Carpenters Welfare Fund Plan Document is hereby amended as follows:

1. Effective October 1, 2021, Article XIII, Section 13.01(N) is amended to read as follows:

(N) Food supplements or baby formulas, unless administered through a feeding tube or orally with the diagnosis of eosinophilic gastroenteritis.

2. Effective January 1, 2022, the Fund name is changed to the "Mid-America Carpenters Regional Council Health Fund." The following changes are made to the Plan:

Article I, Establishment and Name of the Plan, Section 1.01 is amended to read as follows:

Section 1.01 Establishment and Name of the Plan

The Board of Trustees of the Mid-America Carpenters Regional Council Health Fund (prior to January 1, 2022, the Chicago Regional Council of Carpenters Welfare Fund), hereinafter referred to as the "Fund," hereby establishes a health and welfare plan for the Participants hereunder, which plan shall be known as the "Mid-America Carpenters Regional Council Health Plan" (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Welfare Plan"), hereinafter referred to as the "Plan." The Plan was established and is maintained in accordance with the provisions of the Agreement and Declaration of Trust effective August 8, 1952, as amended and restated effective January 1, 2017 (hereafter referred to as "Trust Agreement"). For purposes of ERISA, this Plan is deemed a "health and welfare plan."

Article II, Definitions, Section 2.05 is amended to read:

Section 2.05 Apprentice Program

"Apprentice Program" means the Mid-America Carpenters Regional Council Apprentice and Training Program (prior to January 1, 2022, the Chicago Regional Council of Carpenters Apprentice and Training Program).

Article II, Section 2.28 is amended to read:

Section 2.28 Deferred Lather

"Deferred Lather" means a Participant who is vested in Local No. 74, Wood, Wire, and Metal Lathers' International Union of Chicago and Vicinity Pension Plan ("Lather Plan") and:

(A) Was not actively working as a Lather at the time of the merger in 1983; if a Participant stopped earning credit with the Lather Plan in 1979 or earlier, the Participant is considered "inactive" at the time of the merger; and

(B) The Participant did not earn credit under the Mid-America Carpenters Regional Council Pension Plan (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Plan"), or the Participant earned less than ten (10) years of vesting service under the Mid-America Carpenters Regional Council Pension Plan (previously, the "Chicago Regional Council of Carpenters Pension Plan").

Article II, Section 2.39 is amended to read:

Section 2.39 Employee

"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 Health Fund pursuant to a Collective Bargaining Agreement; or

(B) For whom the Employer is obligated to contribute to the Health Fund pursuant to a written Participation Agreement or other written agreement.

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

Article II, Section 2.45 is amended to read:

Section 2.45 Fund, Trust Fund, or Health Fund

"Fund," "Trust Fund," or "Health Fund" means the Mid-America Carpenters Regional Council Health Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Welfare Fund").

Article II, Section 2.62, is amended to read:

Section 2.62 Negotiated Rate

"Negotiated Rate" means an amount for services rendered that does not exceed the amount agreed upon under the contract between the Health Fund's Contracted Provider and the service provider who participates in the Contracted Provider's Network.

Article II, Section 2.72 is amended to read:

Section 2.72 Pension Funds

"Pension Funds" means collectively the Mid-America Carpenters Regional Council Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Fund"), the Mid-America Carpenters Regional Council Millmen Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Fund"), the Carpenters Pension Fund of Illinois, and the Will County Local 174 Carpenters Pension Fund.

Article II, Section 2.73 is amended to read:

Section 2.73 Pension Plans

"Pension Plans" means collectively the Mid-America Carpenters Regional Council Pension Plan (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Plan"), the Mid-America Regional Council Millmen Pension Plan (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Plan"), the Carpenters Pension Fund of Illinois Plan, and the Will County Local 174 Carpenters Pension Plan.

Article II, Section 2.75 is amended to read:

Section 2.75 Plan, Benefit Plan, Plan of Benefits or Health Plan

"Plan," "Benefit Plan," "Plan of Benefits" or "Health Plan" means this Mid-America Carpenters Regional Council Health Plan (prior to January 1, 2022, "Chicago Regional Council of Carpenters Welfare Plan"), or the plan or program of benefits provided by the Plan set forth in this 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.

Article II, Section 2.93 is amended to read:

Section 2.93 Trust Agreement

"Trust Agreement" means the Mid-America Carpenters Regional Council Health Fund Trust Agreement (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Welfare Trust Agreement") as amended from time to time, establishing the Trust Fund and its rules of operation.

Article II, Section 2.94 is amended to read:

Section 2.94 Trustee, Trustees, or Board of Trustees

"Trustee," "Trustees," or "Board of Trustees" means a Trustee or the Trustees of the Mid-America Carpenters Regional Council Health Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Welfare Fund").

Article II, Section 2.96 is amended to read:

Section 2.96 Union or Council

"Union" or "Council" means the Mid-America Carpenters Regional Council of the United Brotherhood of Carpenters and Joiners of America (prior to October 20, 2021, the "Chicago Regional Council of Carpenters, United Brotherhood of Carpenters and Joiners of America") and affiliated local Unions as identified in the Trust Agreement.

Article III, Eligibility, Section 3.03, Eligibility for Retirees and Certain Eligible Dependents, subsection (A)(1) is amended to read:

(1) Is receiving pension benefits from the Mid-America Carpenters Regional Council Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Fund") or the Mid-America Carpenters Regional Council Millmen Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Fund") based on at least ten (10) years of Eligibility Service. If at some time the Participant did not earn Eligibility Service for a period of three (3) or more consecutive

Calendar Years, the pension must be based on at least fifteen (15) years of Eligibility Service.

Article III, Section 3.07, Premium Payments for Retiree Coverage, subsection (A)(5) is amended to read:

(5) Each Covered Individual will have their premiums determined on a tiered basis, with premium amounts determined by the years of Eligibility Service that a Participant earned with the Mid-America Carpenters Regional Council Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Fund"); Mid-America Carpenters Regional Council Millmen Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Fund"); or the Carpenters Pension Fund of Illinois; or by the years of Eligibility Service as determined in accordance with Plan Section 3.03(A)(5) under the Will County Local 174 Carpenters Pension Fund. Surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) will have the same premium rate tier as the deceased Participant.

Article III, Section 3.11, Continuing Eligibility for the Active Plan Through Self-Payment of Hours, subsection (A)(1) is amended to read:

(1) "Current Hourly Contribution Rate" means the hourly contribution rate under the terms of the Commercial Area Agreement for Cook, Lake and DuPage Counties between the Mid-America Regional Bargaining Association and the Chicago Regional Council of Carpenters (re-named the "Mid-America Carpenters Regional Council of the United Brotherhood of Carpenters and Joiners of America," effective October 20, 2021) and the collective bargaining agreement between the Residential Construction Employers Council and the Chicago Regional Council of Carpenters (re-named the "Mid-America Carpenters Regional Council of the United Brotherhood of Carpenters and Joiners of America" after October 20, 2021), as each is determined from time-to-time, or such other contribution rate that the Trustees may adopt from time-to-time.

Article III, Section 3.21, Credit for Hours received under Reciprocal Agreements, is amended to read:.

Section 3.21 Credit for Hours received under Reciprocal Agreements

(A) Reciprocal Agreements with Other Health and Welfare Funds in the Area. The Health Fund has entered into reciprocal agreements with other health and welfare funds in nearby areas (referred to as "Out of Area Funds"). The reciprocal agreements allow the Participant to receive credit for the hours the Participant worked for employers contributing to the Out of Area Funds, provided Contributions are paid by employers to these Out of Area Funds on behalf of the Participant and are transferred to the Health Fund. Reciprocal contributions are converted before they are credited when the hourly rates differ.

(B) United Brotherhood of Carpenters International Reciprocal Agreement: If the Participant works temporarily in the jurisdiction of an Out of Area Fund that is not a party to an existing reciprocal agreement with the Health Fund, but which participates in the International Reciprocal Agreement, the Participant may request the Out of Area Fund to transfer Contributions paid on the Participant's behalf to the Health Fund. These

Contributions will then be converted to hours under the Health Fund and applied toward the Participant's eligibility for benefits under the Health Fund.

(C) Participants who are working in another jurisdiction that have agreed to participate in a Reciprocal Agreement must immediately contact the Contributions department of the Health Fund to request a Reciprocal Transfer of Hours Form. The Participant must complete the form and return it to the Health Fund. The Health Fund will then forward the form to the Out of Area Fund. Before hours can be credited, the Health Fund must receive the hours and Contribution payments from the Out of Area Fund. When the hours and Contribution payments are received by the Health Fund, the Participant will receive credit. Because some area funds have a lower rate than the Health Fund, the Participant may not receive a full hour of credit for each hour that is transferred.

(D) The reciprocity agreement will establish the manner in which Contributions will be transferred to the Health Fund. The Plan shall govern the manner in which the Health Fund will maintain eligibility and provide benefits for Participants covered by a reciprocity agreement. Other than transferring Contributions pursuant to the terms of the reciprocity agreement, the Health Fund shall have no obligations with respect to individuals working in the jurisdiction of an Out of Area Fund under a reciprocity agreement.

Article XI, Life Insurance Benefits, Section 11.04, Beneficiary Designation for the Life Insurance Benefit, subsection (C) is amended to read:

(C) Any amount payable to a beneficiary by the Insurance Company for the Active Plan or by the Health Fund for the Low Cost Medical Plan will be paid to the beneficiary or beneficiaries designated by the Employee in accordance with the following rules:

Article XI, Section 11.07, Extension of Life Insurance Benefits for an Employee Who Becomes Totally and Permanently Disabled under the Active Plan, subsection (E) is amended to read:

(E) Applying for, or qualifying for a Disability Benefit under a Pension Fund does not constitute application for this Life Insurance Benefit extension. The totally and permanently disabled Employee must file a separate application with the Health Fund.

Article XI, Section 11.09, Life Insurance Benefits for a Dependent, is amended to replace the introductory paragraph and subsection (A) with the following:

Section 11.09 Life Insurance Benefits for a Dependent

An Employee's Dependents who are eligible for benefits under the Active Plan or the Low Cost Medical Plan are eligible for a Life Insurance Benefit as determined by the Trustees from time to time and as provided in the Schedule of Benefits for the Active Plan, see Appendix A or for the Low Cost Medical Plan, see Appendix C. In the event of the death of an Employee's Dependent, from any cause at any time, the Life Insurance Benefit will be payable by the Insurance Company for the Active Plan, or by the Health Fund for the Low Cost Medical Plan, in a lump sum to the Employee. The following conditions apply:

(A) If the Employee's Dependent dies while Dependent coverage is in force for that Dependent, the Insurance Company for the Active Plan, or the Health Fund for the

Low Cost Medical Plan, will pay the Employee if the Employee is still living at the time of payment; otherwise payment will be made to the Employee's estate, or, at the option of the Insurance Company or Health Fund, to the Employee's surviving spouse.

Article XI, Section 11.13, Lump Sum Death Benefit for Certain Retirees of the Will County Local 174 Carpenters Pension Fund, is amended to read:

Section 11.13 Lump Sum Death Benefit for Certain Retirees of the Will County Local 174 Carpenters Pension Fund

Upon the death of any Will County Local 174 Carpenters Pension Fund Retiree who: (1) retired on December 1, 2018 or earlier; and (2) was enrolled in the Comprehensive Medical Benefits and the prescription drug benefits at the time of his death, and (3) dies after attaining age sixty-five (65), a lump sum death benefit of four thousand dollars ($4,000) shall be paid by the Health Fund to the beneficiary designated by the Participant. If there is no designated beneficiary, then the benefit shall be payable in the same manner and order of preference set forth in Plan Section 11.04(C)(3).

3. Effective January 1, 2022, Article II, Definitions, Section 2.59, Medically Necessary or Medical Necessity, is amended to add a new subsection (D) to read as follows:

(D) Medical Necessity for the Retiree Plan is determined by the Contracted Provider consistent with its policies and procedures.

4. Effective January 1, 2022, Article V, Comprehensive Medical Benefits, Section 5.04(E)(1) is amended to read:

(1) The Plan provides coverage for Behavioral Health Care.

5. Effective January 1, 2022, Article V, Section 5.04(HH)(1) is amended to read:

(1) The Plan provides coverage for Substance Use Disorders.

6. Effective January 1, 2022, Article V is amended to add a new Section 5.06, Prior Authorization, to read as follows:

Section 5.06 Prior Authorization

In addition to any prior authorization requirements identified in Section 5.04, the Plan requires prior authorization consistent with the Wellbeing Management Program maintained by the Contracted Provider for certain inpatient and outpatient procedures, including, but not limited to:

(1) Inpatient admissions for

a. Hospital

b. Rehabilitation

c. Skilled nursing

d. Long-term acute/subacute care

(2) Outpatient procedures/surgeries:

a. Spinal cord stimulation

b. Artificial intervertebral disc

(3) Behavioral health services:

a. Residential treatment

b. Partial hospital programs

c. Intensive outpatient programs (IOP)

d. Applied behavior analysis (ABA) treatment

e. Outpatient electroconvulsive therapy (ECT)

f. Repetitive transcranial magnetic stimulation (rTMS)

Services that require prior authorization are determined by the Contracted Provider and may change from time to time.

7. Effective January 1, 2022, Article V, Comprehensive Medical Benefits, Section 5.04(X) is amended to read as follows:

(X) Member Assistance Program:

Through its Contracted Provider, the Plan provides support, resources and information for personal and work life issues through a Member Assistance Program ("MAP"), also known as an employee assistance program. A Covered Individual may, but is not required to, obtain services under the MAP prior to receiving the benefits described in Plan Section 5.04(E) or (HH). In addition, if treatment is required beyond the benefits available through the MAP, the provider can continue treatment through the health plan integration with BCBSIL, subject to deductible and coinsurance.

Effective January 1, 2022, Article V, Section 5.04(Y)(2)(a) is amended to read:

(Y) Naprapathy:

(2) The Plan excludes the following:

(a) Naprapathic care for Dependent children younger than age 12;

8. Effective January 1, 2022, Article IX, Health Reimbursement Account (HRA) Program, Section 9.08, Ordering Rules, subsection (A) is deleted. Subsequent sections are renumbered accordingly.

9. Effective March 1, 2022, Article XIX, COVID-19 Temporary Relief, Section 19.05, is amended to read:

Section 19.05 Temporary Expansion of Short Term Disability Benefits

Effective March 1, 2020, the definition of Non-Occupational Illness under the Short Term Disability benefit is temporarily expanded to include coverage for imposed quarantine or self-quarantine of an eligible Employee who is unable to work because their attending Physician has certified that such quarantine is Medically Necessary or appropriate because the eligible Employee has been diagnosed with COVID-19 according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health. This benefit change does not apply to Employees currently covered by Continuation Coverage under COBRA or the Low Cost Medical Plan.

10. Effective January 1, 2022, the Schedule of Benefits for the Active Plan of Benefits, is amended to replace ComPsych with BCBSIL as the Plan's Behavioral Health provider, to replace ComPsych with Lyra Health as the Plan's Member Assistance Program Provider, to remove the preauthorization requirement for bariatric surgery, to allow for up to twelve sessions per calendar year under the Member Assistance Program, to expand the Chiropractic, Acupuncture and Naprapathic Care Benefit to cover Dependent children age twelve and older for up to fifteen visits per calendar year, and to increase the Hearing Aid Benefit maximum to $5,000 once every three years for Dependent children age 18 and younger and once every five years for Participants and Dependents age 19 and older. Amended Appendix A, attached hereto, reflects the above-referenced Amendment.

11. Effective July 1, 2022, the Schedule of Benefits for the Active Plan of Benefits, is amended to increase the weekly Short Term Disability Benefit payment maximum to $550, and to increase the Infertility Services Benefit lifetime maximum to $60,000. Amended Appendix A, attached hereto, reflects the above-referenced Amendment.

12. Effective January 1, 2022, the Schedule of Benefits for the Retiree Plan of Benefits, is amended to add coverage for a Member Assistance Program, provided by Lyra Health, and to expand the Chiropractic, Acupuncture and Naprapathic Care Benefit to cover Dependent children age twelve and older for up to fifteen visits per calendar year. Amended Appendix B, attached hereto, reflects the above-referenced Amendment.

13. Effective January 1, 2022, the Schedule of Benefits for the Low Cost Medical Plan of Benefits, is amended to replace ComPsych with BCBSIL as the Plan's Behavioral Health provider, to replace ComPsych with Lyra Health as the Plan's Member Assistance Program provider, to remove the preauthorization requirement for bariatric surgery, to allow for up to twelve short-term counseling sessions per calendar year under the Member Assistance Program, and to expand the Chiropractic, Acupuncture, and Naprapathic Care Benefit to cover Dependent children age twelve and older for up to fifteen visits per calendar year. Amended Appendix C, attached hereto, reflects the above-referenced Amendment.

14. Effective July 1, 2022, the Schedule of Benefits for the Low Cost Medical Plan of Benefits, is amended to increase the Infertility Services Benefit lifetime maximum to $60,000. Amended Appendix C, attached hereto, reflects the above-referenced Amendment.

Appendix A

SCHEDULE OF BENEFITS
FOR THE ACTIVE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Active Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per Covered Individual $900 per family	$600 per Covered Individual $1,800 per family
Out-of-Pocket Maximum per Calendar Year	$2,300 per Covered Individual $6,900 per family (includes Calendar Year Deductible)	$6,000 per Covered Individual $18,000 per family (Does not include Calendar Year Deductible)
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined	

MEDICAL BENEFITS
Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care,* page App A-2	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Behavioral Health Care**	See page App. A-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation support and counseling o Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care** (Combined Benefit)	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
	See Plan Sections 5.04(H)	
• **Contraceptives**, including related office visits, to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	80% paid by Plan	60% paid by Plan
	Annual Dental Benefit must be exhausted	

	Absolute Solutions Network	BCBS PPO Provider	Out-of-Network Provider
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	100% paid by Plan (Calendar Year Deductible does not apply)	80% paid by Plan	60% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room** o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Hearing Benefit**		
o Hearing evaluation/exam for a newborn (ages 0 to 31 days) as required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	80% paid by Plan Calendar Year Deductible does not apply
o Hearing evaluation/exam	Paid at 100% per Covered Individual once every two (2) consecutive Calendar Years. Calendar Year Deductible does not apply	No coverage
o Hearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)** / **BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $5,000 maximum per Covered Individual once every three (3) consecutive Calendar Years Calendar Year Deductible does not apply	
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years Calendar Year Deductible does not apply	

	BCBS PPO Provider	Out-of-Network Provider
• **Home Health Care**	80% paid by Plan	60% paid by Plan
	Maximum of 120 visits per year	
• **Hospice Care**	80% paid by Plan	60% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
• **Hospital Care**	80% paid by Plan	60% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments. except diagnostic genetic testing which may be covered above	80% paid by Plan	60% paid by Plan
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan
• **Member Assistance Program**	See page App. A-5	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App A-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
• **Oral and Maxillofacial Surgery**	80% paid by Plan	60% paid by Plan
• **Organ Transplant**	80% paid by Plan	60% paid by Plan
• **Physician Services**	80% paid by Plan	60% paid by Plan
• **Pregnancy Care**	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan
• **Prosthetics**		
o Artificial limbs and eyes	80% paid by Plan	60% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum. Calendar Year Deductible does not apply	
• **Reconstructive Breast Surgery**	80% paid by Plan	60% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See page App. A-5	
• **Surgi-Center Facility** o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
Therapy Services • **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• Premium Lens replacements in conjunction with cataract surgery	$1,000 maximum per lens (maximum two lenses per lifetime)	$1,000 maximum per lens (maximum two lenses per lifetime)
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see **www.healthcare.gov** for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)[1]		
	BCBS In-Network Provider	**Out-of-Network Provider**
• **Emergency Room**	80% paid by Plan	80% paid by Plan
o Facility	80% paid by Plan	80% paid by Plan
o Physician fees		
• **Emergency Room Co-payment**	$250 per Emergency Room Visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days	
• **Hospital Outpatient Diagnostic Tests**	80% paid by Plan	60% paid by Plan
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

[1]Lyra Health providers may also qualify as Network Providers to the extent they provide services under the Plan's Health Plan Integration Program.

VISION CARE BENEFITS Contracted Network Provider: Vision Service Plan of Illinois (VSP) Vision coverage is provided by the contracted provider and is described in the insurance policy issued by the contracted provider. Vision coverage includes, but is not limited to:		
	VSP In-Network Provider (Participant's Cost)	**Out-of-Network Provider (Maximum Amount Plan Pays)**
Frequency • **Exam** • **Lenses or contacts** • **Frame**	Once per Calendar Year	
Exam Co-payment	$0 Co-pay	Up to $45
Frame Allowance • Frames up to $200 ($220 for VSP featured frame brands)	$0 Co-pay* *20% savings on amounts above allowance	Up to $70
Lenses • Single vision • Bifocal lined • Trifocal lined • Standard progressive lens • Premium progressive lens • Custom progressive lens	 $0 Co-pay $0 Co-pay $0 Co-pay $0 Co-pay $95-$105 Co-Pay 150-$175 Co-pay	 Up to $30 Up to $50 Up to $65 Up to $50 Up to $50 Up to $50
Contacts (in lieu of Glasses) • $125 allowance for contacts • Contact lens exam (fitting and evaluation)	$0 Co-pay $40	Up to $105
Safety Glasses (Employees Only) • **Safety Frame** from the ProTec Eyewear Collection • **Lenses –** Prescription single vision, lined bifocal and lined trifocal. Polycarbonate and Progressives covered in full	$10 Co-Pay for frame and lenses	No coverage

DENTAL BENEFITS

Contracted Network Provider: Delta Dental of Illinois

Dental benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Annual Maximum	$2,500		
Annual Deductible (applies only to Basic and Major Care)	$50/person / $100/family		
Balance Billing (the difference between the dentist's actual charge and the amount allowed by Delta Dental.)	Does not apply	Does not apply	Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance
• **Preventive/Diagnostic Care (1)**			
o Covered Individual through age 18	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum
o Covered Individual - age 19 and older	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum
• **Basic Care (2)** (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Major Care (3)** (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Orthodontia (4)**	Effective January 1, 2020, when services are rendered by a Delta Dental provider, the orthodontia charges are paid at 80% subject to a lifetime maximum of $5,000.		Paid at 80% of the Dentist's usual fee subject to a lifetime maximum of $2,000

(1) Preventive/Diagnostic Care includes:

- ✓ Oral evaluations (two in 12 month period)
- ✓ Prophylaxis/Cleaning (two in a 12 month period)
- ✓ X-rays (bitewings two in a 12 month period; full mouth or panoramic once in 36 month period; cephalometric once in a 24 month period)
- ✓ Fluoride Treatment (once in a 12 month period for Dependent children through age 18)
- ✓ Palliative Treatment
- ✓ Sealants (once per lifetime on 1st and 2nd molars only, for Dependent children through age 14)

(2) Basic Care includes:

- ✓ Fillings
- ✓ Oral Surgery
- ✓ General Anesthesia
- ✓ Periodontics
- ✓ Endodontics
- ✓ Consultations
- ✓ Removal of cysts & tumors in the mouth
- ✓ Space Maintainers (5-year interval for Dependent children up to age 13)

(3) **Major Care includes** (services are covered once in a 5 year period) include:	
✓ Crowns, Jackets & Case Restoration	✓ Veneers (Permanent Teeth Only)
✓ Fixed & Removable Bridges	✓ Implants and related services
✓ Partial & Full Dentures	

Note: All Frequency limitations listed above are to the day.

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and

Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Select Specialty Medications	Does not apply		See Plan Sections 8.01(D) and 8.02.

SHORT TERM DISABILITY BENEFITS

(For Employees Only)

Non-Occupational (Not work-related)	Weekly benefits include a payment up to $550 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational (Work-related)	Weekly benefits include credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.

LIFE INSURANCE BENEFITS

Contracted Provider: The Hartford

	Eligible Participant	**Spouse**	**Child**
Policy amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS FOR ELIGIBLE EMPLOYEES ONLY Contracted Provider: The Hartford				
Type of Loss	**Benefit Amount**		**Type of Loss**	**Benefit Amount**
Life	$50,000		Both feet	$50,000
One hand and one foot	$50,000		Both hands	$50,000
One foot and sight of one eye	$50,000		Sight of one eye	$25,000
One hand and sight of one eye	$50,000		One foot	$25,000
Sight of both eyes	$50,000		One hand	$25,000
Speech and hearing in both ears	$50,000		Thumb and index finger	$12,500

Appendix B

SCHEDULE OF BENEFITS
FOR THE RETIREE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Retiree Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per Covered Individual $600 per family	$600 per Covered Individual
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family (includes deductible)	$6,000 per Covered Individual
	After a Covered Individual satisfies the deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO deductibles and Out-of-Pocket Maximums are separate and cannot be combined	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit), see page App B-2*	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Behavioral Health Care**	See page App. B-5	
• **Breast Feeding Support and Equipment** as required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
• **Contraceptives,** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	80% paid by Plan	60% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room** o Facility o Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Hearing Benefit** o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)	
oHearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)** / **BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply	
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply	
	BCBS PPO Provider	**Out-of-Network Provider**
• **Home Health Care**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Hospice Care**	80% paid by Plan	60% paid by Plan
	Lifetime maximum of 180 days per individual	
• **Hospital Care**	80% paid by Plan	60% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing, which may be covered above	80% paid by Plan	60% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan
• **Member Assistance Program**	See page App. B-5	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App B-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No Coverage
• **Oral and Maxillofacial Surgery**	80% paid by Plan	60% paid by Plan
• **Organ Transplant**	80% paid by Plan	60% paid by Plan
• **Physician Services**	80% paid by Plan	60% paid by Plan
• **Pregnancy Care**	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan
• **Prosthetics** o Artificial limbs and eyes	80% paid by Plan	60% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum Calendar Year Deductible does not apply	
• **Reconstructive Breast Surgery**	80% paid by Plan	60% paid by Plan

	BCBS In-Network Provider	Out-of-Network Provider
• **Sterilization**		
o Females to the extent required under the Affordable Care Act	100% paid by Plan, Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See Page App. B-5	
• **Surgi-Center Facility**		
o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ)		
o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services**		
o **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Covered Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE	
• **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)[2]		
	BCBS In-Network Provider	**Out-of-Network Provider**
• **Emergency Room** oFacility	80% paid by Plan	80% paid by Plan
oPhysician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours. Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement Maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN HOSPITAL BENEFITS ONLY AS DESCRIBED IN PLAN SECTION. 5.04(U) **Per Benefit Period*** ***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.** Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)	
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)**	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible
o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 days	Plan pays 100% of Medicare eligible expenses

[2] Lyra Health providers may also qualify as Network Providers to the extent they provide services under the Plan's Health Plan Integration Program.

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS
Per Benefit Period*

***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.**

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)***	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible
o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 Days	Plan Pays 100% of Medicare eligible expenses
• **Medicare Part B Supplement**	
o Medicare Part B Deductible	Plan pays Medicare Part B Deductible
o Medical expenses	Plan pays 20% of Medicare eligible expenses at the Medicare approved amount, after the Medicare Part B Deductible
• **Blood**	Plan pays for three (3) pints
• **Skilled Nursing Facility Care*** - Covered Individual must meet Medicare's requirements, including having been in a Hospital for at least three days and enter a Medicare approved facility within 30 days of leaving the Hospital	
o First 20 days	Medicare pays all approved amounts
o 21st through 100th day	Plan pays Medicare Part A Co-Payment
• **At Home Recovery Services Not Covered by Medicare** – Home care certified by a Covered Individual's Doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home treatment plan.	
o Benefit for each visit	Plan pays up to $40 per visit Up to a Calendar Year Maximum of $1,600
• **Foreign Travel**	
o Calendar Year Deductible	$250 per Covered Individual
	Plan pays 80%. The Plan does not pay for expenses in excess of the Reasonable and Customary Allowance for non-PPO Out-of-Network providers. Amounts over the Reasonable and Customary Allowance are the Covered Individual's responsibility
o Lifetime Maximum for Foreign Travel	$50,000

• **Hearing Benefit** o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
oHearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply		
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply		

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year Calendar Year Deductible does not apply	No coverage

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

PRESCRIPTION BENEFIT

Contracted Network Provider: Express Scripts, Inc. (ESI) and Accredo Specialty Pharmacy

Not available to Deferred Lathers or to Medicare-eligible individuals with Medicare Part D coverage.

	ESI Network Retail Pharmacy (Lesser of 100 pills or a 30 day supply)	**ESI by Mail** (Up to a 90-day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Single-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Non-Select Specialty Medication Out-of-Pocket Maximum per Calendar Year	Does not apply		$1,500 per individual / $3,000 per family
Select Specialty Medications (Co-payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.04.

INSURED BENEFITS	CARRIER
• Dental Benefits	Delta Dental of Illinois
• Vision Benefits	Vision Service Plan of Illinois (VSP)
• Life Insurance Benefit ($25,000, Retirees Under Age 65 Only)	The Hartford

Appendix C

SCHEDULE OF BENEFITS
FOR THE LOW COST MEDICAL PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Low Cost Medical Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	70% paid by Plan	50% paid by Plan
Deductible per Calendar Year	$600 per Covered Individual / $1,800 per family	
Out-of-Pocket Maximum per Calendar Year	$4,600 per Covered Individual / $9,200 per family (includes Deductible)	
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible covered services for the remainder of the Calendar Year.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care, page App C-2*	
• **Ambulance Service**	70% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	70% paid by Plan	50% paid by Plan
• **Behavioral Health Care**	See page App. C-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	70% paid by Plan	50% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year. Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12	
• **Clinical Trials** to the extent required by the Affordable Care Act	70% paid by Plan	50% paid by Plan
	See Plan Section 5.04(H)	
• **Contraceptives** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	70% paid by Plan	50% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	70% paid by Plan	50% paid by Plan
• **Durable Medical Equipment**	70% paid by Plan	50% paid by Plan
• **Emergency Room**	70% paid by Plan	70% paid by Plan
o Facility fees o Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	70% paid by Plan	50% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	50% paid by Plan Subject to Calendar Year Deductible, Subject to Out-of-Pocket Maximums and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	70% paid by Plan	50% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage
• **Hearing Benefit**	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
• **Home Health Care**	70% paid by Plan	50% paid by Plan
	Maximum of 120 visits per year	

	BCBS PPO Provider	Out-of-Network Provider
• **Hospice Care**	70% paid by Plan	50% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
• **Hospital Care**	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing which may be covered above	70% paid by Plan	50% paid by Plan
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	70% paid by Plan	50% paid by Plan
• **Member Assistance Program**	See page App. C-4	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App C-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
• **Oral and Maxillofacial Surgery**	70% paid by Plan	50% paid by Plan
• **Organ Transplant**	70% paid by Plan	50% paid by Plan
• **Physician Services**	70% paid by Plan	50% paid by Plan
• **Pregnancy Care**	70% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Deductible does not apply.	50% paid by Plan
• **Prosthetics** o Artificial limbs and eyes	70% paid by Plan	50% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	No coverage	
• **Reconstructive Breast Surgery**	70% paid by Plan	50% paid by Plan
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No Coverage
o Males	70% paid by Plan	No Coverage
o Sterilization reversals (female/male)	No Coverage	No Coverage
• **Substance Use Disorder**	See page App. C-5	
• **Surgi-Center Facility** o Hospital Affiliated	70% paid by Plan	50% paid by Plan
o No Hospital Affiliation	70% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	70% paid by Plan	50% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	70% paid by Plan	50% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	70% paid by Plan	50% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	70% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services** o **Physical and Speech Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
o **Occupational Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
o **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	70% paid by Plan	50% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	70% paid by Plan	50% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	70% paid by Plan	50% paid by Plan
• **Wellness and Preventive Care** o **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Participant and spouse once every Calendar Year. Calendar Year Deductible does not apply. No coverage for Dependent children	

HEALTH CENTER For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out of Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year Calendar Year Deductible does not apply.	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL), Guidance Resources®		
	BCBSIn-Network Provider[3]	**Out of Network Provider**
• **Emergency Room** o Facility	70% paid by Plan	70% paid by Plan
o Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	70% paid by Plan	50% Paid by Plan
	Confinement maximum: 180 days per calendar year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Hospital Outpatient Diagnostic Tests**	70% paid by Plan	50% paid by Plan
• **Outpatient Therapy** (Including Partial Hospitalization)	70% paid by Plan	50% paid by Plan
• **Custodial or Group Homes**	No coverage	

PRESCRIPTION BENEFITS Contracted Network Provider: Express Scripts, Inc. and Accredo Specialty Pharmacy Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.			
	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	70% paid by Plan		Does not apply
Single-Source Brand Co-payment (A generic is not available)	70% paid by Plan		Does not apply
Multi-Source Brand Co-payment (A generic is available)	70% paid by Plan		Does not apply
Non-Select Specialty Medication Co-payment (Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		70% paid by Plan
Select Specialty Medications (Co-Payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.03.

[3] Lyra Health providers may also qualify as Network Providers to the extent they provide services under the Plan's Health Plan Integration Program.

LIFE INSURANCE BENEFITS Contracted Provider: Self-Funded			
	Eligible Participant	**Spouse**	**Child**
Policy amount	$5,000	$1,000	$1,000

EXCLUDED BENEFITS	
Vision Benefits	No coverage
Dental Benefits	No coverage
Short Term Disability Benefits	No coverage
Accidental Death and Dismemberment Insurance Benefits	No coverage

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RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund"):

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Union and Associations have negotiated payment of post-tax contributions to the Fund effective June 1, 2022 for the purpose of providing vacation benefits to eligible Employees;

WHEREAS, the Trustees desire to amend the Plan effective June 1, 2022, to clarify criteria for commencement of short-term disability benefits for participants who have received disability benefits and experience a subsequent disability;

WHEREAS, the Trustees desire to amend the Plan effective June 1, 2022, to establish a vacation benefit;

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 5, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Jr. Chairman — Date: 5/25/2022

Gerald W. Thiel, Jr., Secretary — Date: 5/25/22

EXHIBIT A

AMENDMENT NO. 5 TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN DOCUMENT
(RESTATED EFFECTIVE DECEMBER 1, 2020)

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective June 1, 2022, current Article X, Short-Term Disability Benefits, Section 10.1 is amended and restated to read as follows:

Section 10.1 Short Term Disability Benefits under the Active Plan

(C) Subsequent Disability: A new Claim for Short Term Disability Benefits will begin only if one of the following two (2) criteria are met:

(1) A subsequent Disability is due to a Non-Occupational Illness or Injury or Occupational Illness or Injury unrelated to the previous Disability; and is separated by a return to work for at least 200 hours of Covered Employment with one (1) or more Employers; or

(2) If a subsequent Disability is caused by a Non-Occupational Illness or Injury or Occupational Illness or Injury related to a previous Disability, the Employee must provide proof of recovery from the previous Illness or Injury and must remain non-Disabled for a period of at least twelve (12) consecutive months before the Employee can apply for a new Short Term Disability claim.

2. Effective June 1, 2022, Article XIX is added to the Plan to read as follows:

Section 19.01 General

All contributions that Employers submit to the Fund that are designated as post-tax vacation contributions ("Vacation Contributions") will be segregated and credited to the account ("Vacation Account") of the Employee on whose behalf the Employer is contributing for the purpose of funding a vacation benefit ("Vacation Benefit") for the Employee. Employee self-contributions are not permitted and Vacation Contributions are not subject to reciprocity.

Section 19.02 Accumulation of Benefits

Vacation Contributions that accumulate in an Employee's Vacation Account for the period of July through June, consistent with the Plan Year, will fund the Employee's Vacation Benefit for

that Plan Year. Vacation Benefits shall be paid annually as soon as administratively feasible following the end of each Plan Year but, in no event, later than 30 days following the end of the Plan Year provided the Administrator possesses for the Employee either a valid: (a) direct deposit banking direction or (b) address.

All Vacation Contributions must be received by the Administrator before June 30 of each Plan Year to be credited to the Employee's Vacation Account available to be distributed as a Vacation Benefit for that Plan Year.

Section 19.03 Administration

(a) The Trustees have adopted procedures to govern the accounting, payment, distribution, and reconciliation of Vacation Benefits.

(b) The Trustees reserve the right to change or adopt additional procedures to ensure the proper administration and payment of Vacation Benefits.

Section 19.04 Payment of Benefits

(a) Vacation Benefits are paid after June 30 of each Plan Year after the deduction of appropriate administrative expenses and reconciliation of Vacation Contributions.

(b) Employees may elect on forms provided by the Administrator to receive their Vacation Benefits through direct deposit or mail. If an Employee fails to direct the Administrator regarding the manner of payment prior to deadlines that may be established for such elections, then the Vacation Benefit will be delivered by mail to the address on record with the Administrator. No distribution fee will apply to Vacation Benefits distributed by direct deposit. Vacation Benefits distributed by mail will be subject to a distribution fee established by the Trustees. If a direct deposit attempt is rejected by the Employee's bank, the Fund shall mail a check payment reduced by the distribution fee. All distributions will occur as soon as administratively feasible following the end of the Plan Year but, in no event, later than 30 days following the end of the Plan Year provided the Administrator possesses for the Employee either a valid: (a) direct deposit banking direction or (b) address.

(c) If there is a balance in an Employee's Vacation Account at the time of his or her death, that balance shall be paid consistent with the Beneficiary distribution rules identified in Section 11.04.

Section 19.05 Unclaimed Benefits

(a) The Fund has adopted appropriate procedures to regularly review when a check is returned or is unclaimed. If after exhausting these procedures the Fund is unable to locate the Employee or deliver the check, the payment will be temporarily forfeited subject to re-issue if the Employee subsequently pursues payment. The Fund will follow similar procedures, including temporary forfeitures, for checks that are delivered but not negotiated. The Fund may issue a stop pay order where necessary.

Section 19.06 Benefits and Initial Claims

(a) Vacation Benefit payments are made automatically on an annual basis equal to Vacation Contributions the Fund receives from Employers during the Plan Year. The Fund will automatically distribute Vacation Benefits following the end of each Plan Year without requiring Employees to file a claim for Vacation Benefits. Employees who do not receive a Vacation Benefit or who believe they are entitled to additional Vacation Benefits may file a claim with the Administrator and such claims will be subject to Article XVI.

3. Effective June 1, 2022, current Article XIX ("COVID-19 Temporary Relief") shall be re-numbered Article XX with all sections therein numbered accordingly.

PRESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund"):

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan to incorporate changes required under the Consolidated Appropriations Act, 2021;

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 6, as set forth as Exhibit A attached hereto, effective July 1, 2022.

Gary Perinar, Chairman — Date: AUG. 17, 2022

Gerald W. Thiel, Jr., Secretary — Date: AUG 17 2022

EXHIBIT A

AMENDMENT NO. 6 TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN DOCUMENT
(RESTATED EFFECTIVE DECEMBER 1, 2020)

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended effective July 1, 2022 as follows:

1. The following new sections are added to Article II, Definitions. All subsequent sections and cross references are renumbered accordingly.

Section 2.16 Continuing Care Patient

"Continuing Care Patient" means a Covered Individual who, with respect to a provider or facility:

(A) Is undergoing a course of treatment for a serious and complex condition from the provider or facility. 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;

(B) Is undergoing a course of institutional or inpatient care from the provider or facility;

(C) Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(D) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) Was determined to be terminally ill and is receiving treatment for such Illness from such provider or facility.

Section 2.17 Continuing Care Services

"Continuing Care Services" means items and services provided to a Continuing Care Patient by a Non-PPO provider that relate to the Covered Individual'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 PPO network and ending on the earlier of the 90-day period or the date the Covered Individual's current course of treatment ends.

Section 2.41 Emergency Services

"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-PPO provider that the Plan would cover if furnished by a PPO provider after the Covered Individual 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 Physician or treating provider determines the Covered Individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO provider located within a reasonable travel distance, taking into account the individual's medical condition;

(B) The Non-PPO provider furnishing such additional items and services satisfies the notice and consent requirements of the No Surprises Act;

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

(D) The Non-PPO provider satisfies any additional requirements or prohibitions imposed under state law.

Section 2.67 No Surprises Act

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

Section 2.83 Protected Service

"Protected Service" means:

(A) Emergency Services furnished by a Non-PPO provider or facility;

(B) Air ambulance services furnished by a Non-PPO 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-PPO provider at a PPO facility; and

(D) Other items and services furnished by a Non-PPO provider at a PPO Hospital, Hospital outpatient department, or ambulatory surgical center if such items and services would be covered by the Plan if furnished by a PPO provider and the

provider does not satisfy the notice and consent requirements under the No Surprises Act.

2. Article II, Definitions, Section 2.37 is amended to read:

Section 2.37 Emergency or Emergencies

"Emergency" means a severe condition that results from acute symptoms that a prudent layperson with average knowledge of health and medicine would expect the absence of immediate medical attention to result in:

(A) Placing the health of the individual (or, regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

3. Article II, Definitions, Section 2.38 is amended to read:

Section 2.38 Emergency Room

"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. "Emergency Room" also means an independent freestanding emergency department that is geographically distinct and licensed separately from a Hospital under the laws of the state of its jurisdiction and provides Emergency Services.

4. Article II, Definitions, Section 2.80, is amended to read:

Section 2.80 Reasonable and Customary Allowance, Reasonable and Customary Allowable Charge or Reasonable and Customary Charge

"Reasonable and Customary Allowance," "Reasonable and Customary Allowable Charge" or "Reasonable and Customary Charge" means the allowance or percentage for Medically Necessary services or supplies as determined by the Trustees (or their designee such as a third party Claims Fiduciary) in their sole discretion as set forth in the Schedules of Benefits in Appendices A, B and C, as amended from time to time. For Protected Services, the Reasonable and Customary Allowance shall be applied in accordance with the No Surprises Act. In no case will the Reasonable and Customary Allowance exceed charges actually incurred.

5. Article V, Comprehensive Medical Benefits, Section 5.01(B) is amended to read:

(B) The PPO Deductible and Non-PPO Deductible are separate Deductibles and cannot be combined to reach maximums. Covered Medical Expenses for Protected Services and Continuing Care Services apply to satisfy only the PPO Deductible.

6. Article V, Comprehensive Medical Benefits, Section 5.02(C) is amended to read:

(C) PPO and Non-PPO Out-of-Pocket expenses are separate and cannot be combined to reach Out-of-Pocket Maximums. Cost-sharing amounts that a Covered Individual pays for Protected Services and Continuing Care Services count only toward the PPO Out-of-Pocket Maximum.

7. Article V, Comprehensive Medical Benefits, Section 5.04(O) is amended to read:

(O) Emergency Room Services:

The Plan covers Emergency Room Services as follows:

(1) An Emergency Room Co-payment is applicable when a Covered Individual utilizes an Emergency Room and is treated and released without being admitted to the Hospital as an inpatient;

(2) The Emergency Room Co-payment will not apply:

(a) If a Covered Individual is admitted to the Hospital as an inpatient for the same condition within seventy-two (72) hours of the Emergency Room visit;

(b) If a Covered Individual utilizes a Hospital Emergency Room and is subsequently held in the observation unit of the Hospital for more than twenty-four (24) hours;

(c) If the condition is so severe that it results in death of the Covered Individual while in the Emergency Room;

(d) If a Covered Individual has met the applicable Out-of-Pocket Maximum.

(3) Non-PPO charges will be considered at the applicable PPO Coinsurance rate, subject to the PPO Calendar Year Deductible and applied toward the PPO Out-of-Pocket Maximum.

8. Article XVI, Claims and Appeals, Section 16.09(B)(3) is amended to read:

(3) 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.

9. Article XVI, Claims and Appeals, the first paragraph of Section 16.10 is amended to read:

If an appealed Health Care Claim is denied by the Appeals Committee of the Board of Trustees or a third-party 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.

10. Article XVI, Claims and Appeals, Section 16.10(A) is amended to read:

(A) A request for an external review of a non-urgent Claim must be made, in writing, within four (4) 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.

11. Appendices A, B, and C are amended and restated in their entirety to read as set forth in the attached Exhibit I.

EXHIBIT I

Appendix A

SCHEDULE OF BENEFITS
FOR THE ACTIVE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Active Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). Except as required by law for Protected Services, R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
	Protected Services and Continuing Care Services are payable at the PPO provider rate.	
Deductible per Calendar Year	$300 per Covered Individual $900 per family	$600 per Covered Individual $1,800 per family
Out-of-Pocket Maximum per Calendar Year	$2,300 per Covered Individual $6,900 per family (includes Calendar Year Deductible)	$6,000 per Covered Individual $18,000 per family (Does not include Calendar Year Deductible)
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined. Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
Acupuncture Care	See *Chiropractic, Acupuncture and Naprapathic Care*, page App A-2	
Ambulance Service	80% paid by Plan subject to the PPO Deductible	
Anesthesia or Sedation	80% paid by Plan	60% paid by Plan
Behavioral Health Care	See page App. A-5	
Breast Feeding Support and Equipment to the extent required under the Affordable Care Act o Lactation support and counseling o Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider		**Out-of-Network Provider**
Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)	80% paid by Plan		60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12		
Clinical Trials to the extent required by the Affordable Care Act	80% paid by Plan		60% paid by Plan
	See Plan Sections 5.04(H)		
Contraceptives, including related office visits, to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply		No coverage
Cosmetic Surgery solely to improve appearance	No coverage		
Dental Service for a Non-Occupational Injury to Teeth	80% paid by Plan		60% paid by Plan
	Annual Dental Benefit must be exhausted		
	Absolute Solutions Network	**BCBS PPO Provider**	**Out-of-Network Provider**
Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans	100% paid by Plan (Calendar Year Deductible does not apply)	80% paid by Plan	60% paid by Plan
	BCBS PPO Provider		**Out-of-Network Provider**
Diagnostic X-Rays and Lab Tests	80% paid by Plan		60% paid by Plan
Durable Medical Equipment	80% paid by Plan		60% paid by Plan
Emergency Services o Facility	80% paid by Plan		80% paid by Plan
o Physician fees	80% paid by Plan		80% paid by Plan
Emergency Room Co-payment	$250 per Emergency Room visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum		
Extended Care/Skilled Nursing Facility	80% paid by Plan		60% paid by Plan
	Maximum of 120 days per convalescent period		
Genetic Testing Benefit o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply		60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan		60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500		
o Non-diagnostic genetic testing	No coverage		No coverage

	BCBS PPO Provider	Out-of-Network Provider
Hearing Benefit		
○ Hearing evaluation/exam for a newborn (ages 0 to 31 days) as required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	80% paid by Plan Calendar Year Deductible does not apply
○ Hearing evaluation/exam	Paid at 100% per Covered Individual once every two (2) consecutive Calendar Years. Calendar Year Deductible does not apply	No coverage
○ Hearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)** / **BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $5,000 maximum per Covered Individual once every three (3) consecutive Calendar Years Calendar Year Deductible does not apply	
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years Calendar Year Deductible does not apply	

	BCBS PPO Provider	Out-of-Network Provider
Home Health Care	80% paid by Plan	60% paid by Plan
	Maximum of 120 visits per year	
Hospice Care	80% paid by Plan	60% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
Hospital Care	80% paid by Plan	60% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days	
Infertility Services including Hospital, Physician, prescription drugs & treatments. except diagnostic genetic testing which may be covered above	80% paid by Plan	60% paid by Plan
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse. No coverage for dependent children.	
Infusion Therapy for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan
Member Assistance Program	See page App. A-5	
Naprapathic Care	See *Chiropractic, Acupuncture and Naprapathic Care*, page App A-2	
Nutritional Counseling to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
Oral and Maxillofacial Surgery	80% paid by Plan	60% paid by Plan
Organ Transplant	80% paid by Plan	60% paid by Plan
Physician Services	80% paid by Plan	60% paid by Plan
Pregnancy Care	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan
Prosthetics ○ Artificial limbs and eyes	80% paid by Plan	60% paid by Plan
○ Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum. Calendar Year Deductible does not apply	
Reconstructive Breast Surgery	80% paid by Plan	60% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
Sterilization		
o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
Substance Use Disorder	See page App. A-5	
Surgi-Center Facility		
o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
Surgical Assistant or Assistant Surgeon	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
Surgical Consultations	80% paid by Plan	60% paid by Plan
Temporomandibular Joint Care (TMJ)		
o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
Therapy Services		
Physical and Speech Outpatient Therapy	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
Occupational Outpatient Therapy	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
Urgent/Immediate Care Facilities and Retail Clinics	80% paid by Plan	60% paid by Plan
Vision Surgery (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
Premium Lens replacements in conjunction with cataract surgery	$1,000 maximum per lens (maximum two lenses per lifetime)	$1,000 maximum per lens (maximum two lenses per lifetime)
Wellness and Preventive Care		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see **www.healthcare.gov** for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS For Eligible Covered Individuals Only	
Health Center Services	100% paid by Plan. Calendar Year Deductible does not apply

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
Member Assistance Program (MAP)	100% paid by Plan for twelve sessions Calendar Year Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)[1]		
	BCBSIL In-Network Provider	**Out-of-Network Provider**
Emergency Services	80% paid by Plan	80% paid by Plan
o Facility	80% paid by Plan	80% paid by Plan
o Physician fees		
Emergency Room Co-payment	$250 per Emergency Room Visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
Hospital Care and Residential Treatment Facilities	80% paid by Plan	60% Paid by Plan
	Confinement maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days	
Hospital Outpatient Diagnostic Tests	80% paid by Plan	60% paid by Plan
Outpatient Therapy (including partial hospitalization)	80% paid by Plan	60% paid by Plan
Custodial or Group Homes	No coverage	

[1] Lyra Health providers may also qualify as Network Providers to the extent they provide services under the Plan's Health Plan Integration Program

VISION CARE BENEFITS Contracted Network Provider: Vision Service Plan of Illinois (VSP) Vision coverage is provided by the contracted provider and is described in the insurance policy issued by the contracted provider. Vision coverage includes, but is not limited to:		
	VSP In-Network Provider (Participant's Cost)	**Out-of-Network Provider (Maximum Amount Plan Pays)**
Frequency • **Exam** • **Lenses or contacts** • **Frame**	Once per Calendar Year	
Exam Co-payment	$0 Co-pay	Up to $45
Frame Allowance • Frames up to $200 ($220 for VSP featured frame brands)	$0 Co-pay* *20% savings on amounts above allowance	Up to $70
Lenses • Single vision • Bifocal lined • Trifocal lined • Standard progressive lens • Premium progressive lens • Custom progressive lens	$0 Co-pay $0 Co-pay $0 Co-pay $0 Co-pay $95-$105 Co-Pay 150-$175 Co-pay	Up to $30 Up to $50 Up to $65 Up to $50 Up to $50 Up to $50
Contacts (in lieu of Glasses) • $125 allowance for contacts • Contact lens exam (fitting and evaluation)	$0 Co-pay $40	Up to $105
Safety Glasses (Employees Only) • **Safety Frame** from the ProTec Eyewear Collection • **Lenses** • Prescription single vision, lined bifocal and lined trifocal. Polycarbonate and Progressives covered in full	$10 Co-Pay for frame and lenses	No coverage

DENTAL BENEFITS

Contracted Network Provider: Delta Dental of Illinois

Dental benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Annual Maximum	$2,500		
Annual Deductible (applies only to Basic and Major Care)	$50/person / $100/family		
Balance Billing (the difference between the dentist's actual charge and the amount allowed by Delta Dental.)	Does not apply	Does not apply	Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance
Preventive/Diagnostic Care (1)			
o Covered Individual through age 18	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum
o Covered Individual - age 19 and older	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum
Basic Care (2) (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
Major Care (3) (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
Orthodontia (4)	Effective January 1, 2020, when services are rendered by a Delta Dental provider, the orthodontia charges are paid at 80% subject to a lifetime maximum of $5,000.		Paid at 80% of the Dentist's usual fee subject to a lifetime maximum of $2,000

(1) Preventive/Diagnostic Care includes:

- ✓ Oral evaluations (two in 12 month period)
- ✓ Prophylaxis/Cleaning (two in a 12 month period)
- ✓ X-rays (bitewings two in a 12 month period; full mouth or panoramic once in 36 month period; cephalometric once in a 24 month period)
- ✓ Fluoride Treatment (once in a 12 month period for Dependent children through age 18)
- ✓ Palliative Treatment
- ✓ Sealants (once per lifetime on 1st and 2nd molars only, for Dependent children through age 14)

(2) Basic Care includes:

- ✓ Fillings
- ✓ Oral Surgery
- ✓ General Anesthesia
- ✓ Periodontics
- ✓ Endodontics
- ✓ Consultations
- ✓ Removal of cysts & tumors in the mouth
- ✓ Space Maintainers (5-year interval for Dependent children up to age 13)

(3) **Major Care includes** (services are covered once in a 5 year period) include:	
✓ Crowns, Jackets & Case Restoration	✓ Veneers (Permanent Teeth Only)
✓ Fixed & Removable Bridges	✓ Implants and related services
✓ Partial & Full Dentures	

Note: All Frequency limitations listed above are to the day.

PRESCRIPTION BENEFITS Contracted Network Provider: Express Scripts, Inc. and Accredo Specialty Pharmacy Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.			
	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Select Specialty Medications	Does not apply		See Plan Sections 8.01(D) and 8.02.

SHORT TERM DISABILITY BENEFITS (For Employees Only)	
Non-Occupational (Not work-related)	Weekly benefits include a payment up to $550 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational (Work-related)	Weekly benefits include credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.

LIFE INSURANCE BENEFITS Contracted Provider: The Hartford			
	Eligible Participant	**Spouse**	**Child**
Policy amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS FOR ELIGIBLE EMPLOYEES ONLY Contracted Provider: The Hartford				
Type of Loss	**Benefit Amount**		**Type of Loss**	**Benefit Amount**
Life	$50,000		Both feet	$50,000
One hand and one foot	$50,000		Both hands	$50,000
One foot and sight of one eye	$50,000		Sight of one eye	$25,000
One hand and sight of one eye	$50,000		One foot	$25,000
Sight of both eyes	$50,000		One hand	$25,000
Speech and hearing in both ears	$50,000		Thumb and index finger	$12,500

Appendix B

SCHEDULE OF BENEFITS
FOR THE RETIREE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Retiree Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C allowance). Except as required by law for Protected Services, R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
	Protected Services and Continuing Care Services are payable at the PPO provider rate.	
Deductible per Calendar Year	$300 per Covered Individual $600 per family	$600 per Covered Individual
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family (includes deductible)	$6,000 per Covered Individual
	After a Covered Individual satisfies the deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO deductibles and Out-of-Pocket Maximums are separate and cannot be combined. Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
Acupuncture Care	See *Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit), see page App B-2*	
Ambulance Service	80% paid by Plan subject to the PPO Deductible	
Anesthesia or Sedation	80% paid by Plan	60% paid by Plan
Bariatric Surgery (only for the diagnosis and treatment of morbid obesity)	80% paid by Plan	60% paid by Plan
	A Covered Individual is required to contact BCBSIL before any treatment is given and must be approved for surgery.	
Behavioral Health Care	See page App. B-5	
Breast Feeding Support and Equipment as required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12	
Clinical Trials to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
Contraceptives, to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
Cosmetic Surgery solely to improve appearance	No coverage	
Dental Service for a Non-Occupational Injury to Teeth	No coverage	
Diagnostic Imaging Benefit MRI, CAT/CT and PET Scans	80% paid by Plan	60% paid by Plan
Diagnostic X-Rays and Lab Tests	80% paid by Plan	60% paid by Plan
Durable Medical Equipment	80% paid by Plan	60% paid by Plan
Emergency Services o Facility o Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
Emergency Room Co-payment	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
Extended Care/Skilled Nursing Facility	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
Genetic Testing Benefit		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

	BCBS PPO Provider	Out-of-Network Provider
Hearing Benefit o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)	
oHearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)** / **BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply	
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply	
	BCBS PPO Provider	**Out-of-Network Provider**
Home Health Care	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
Hospice Care	80% paid by Plan	60% paid by Plan
	Lifetime maximum of 180 days per individual	
Hospital Care	80% paid by Plan	60% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
Infertility Services including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing, which may be covered above	80% paid by Plan	60% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse. No coverage for dependent children.	
Infusion Therapy for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan
Naprapathic Care	See *Chiropractic, Acupuncture and Naprapathic Care*, page App B-2	
Nutritional Counseling to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No Coverage
Oral and Maxillofacial Surgery	80% paid by Plan	60% paid by Plan
Organ Transplant	80% paid by Plan	60% paid by Plan
Physician Services	80% paid by Plan	60% paid by Plan
Pregnancy Care	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan
Prosthetics o Artificial limbs and eyes	80% paid by Plan	60% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum Calendar Year Deductible does not apply	
Reconstructive Breast Surgery	80% paid by Plan	60% paid by Plan

	BCBS In-Network Provider	Out-of-Network Provider
Sterilization		
oFemales to the extent required under the Affordable Care Act	100% paid by Plan, Deductible does not apply	No coverage
oMales	80% paid by Plan	No coverage
oSterilization reversals (female/male)	No coverage	No coverage
Substance Use Disorder	See Page App. B-5	
Surgi-Center Facility		
oHospital affiliated	80% paid by Plan	60% paid by Plan
oNo Hospital affiliation	80% paid by Plan	No coverage
Surgical Assistant or Assistant Surgeon	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C allowance
Surgical Consultations	80% paid by Plan	60% paid by Plan
Temporomandibular Joint Care (TMJ)		
oPhysician and therapy services	80% paid by Plan	60% paid by Plan
oAppliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
Therapy Services		
o**Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o**Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o**Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
Urgent/Immediate Care Facilities and Retail Clinics	80% paid by Plan	60% paid by Plan
Vision Surgery (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
Wellness and Preventive Care		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Covered Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE	
▯ **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
▯ **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS In-Network Provider	**Out-of-Network Provider**
▯ **Emergency Services** o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
▯ **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours. Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
▯ **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement Maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
▯ **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
▯ **Custodial or Group Homes**	No coverage	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN HOSPITAL BENEFITS ONLY AS DESCRIBED IN PLAN SECTION. 5.04(U) **Per Benefit Period*** ***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.** Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)	
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
▯ **Medicare Part A Supplement (Hospital Benefit)**	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible
o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 days	Plan pays 100% of Medicare eligible expenses

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS Per Benefit Period*

***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.**

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
Medicare Part A Supplement (Hospital Benefit)*	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible
o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 Days	Plan Pays 100% of Medicare eligible expenses
Medicare Part B Supplement	
o Medicare Part B Deductible	Plan pays Medicare Part B Deductible
o Medical expenses	Plan pays 20% of Medicare eligible expenses at the Medicare approved amount, after the Medicare Part B Deductible
Blood	Plan pays for three (3) pints
Skilled Nursing Facility Care* - Covered Individual must meet Medicare's requirements, including having been in a Hospital for at least three days and enter a Medicare approved facility within 30 days of leaving the Hospital	
o First 20 days	Medicare pays all approved amounts
o 21st through 100th day	Plan pays Medicare Part A Co-Payment
At Home Recovery Services Not Covered by Medicare – Home care certified by a Covered Individual's Doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home treatment plan.	
o Benefit for each visit	Plan pays up to $40 per visit Up to a Calendar Year Maximum of $1,600
Foreign Travel	
o Calendar Year Deductible	$250 per Covered Individual
	Plan pays 80%. The Plan does not pay for expenses in excess of the Reasonable and Customary Allowance for non-PPO Out-of-Network providers. Amounts over the Reasonable and Customary Allowance are the Covered Individual's responsibility
o Lifetime Maximum for Foreign Travel	$50,000

Hearing Benefit o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
o Hearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply		
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply		

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS	
▯ **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

PRESCRIPTION BENEFIT Contracted Network Provider: Express Scripts, Inc. (ESI) and Accredo Specialty Pharmacy Not available to Deferred Lathers or to Medicare-eligible individuals with Medicare Part D coverage.			
	ESI Network Retail Pharmacy (Lesser of 100 pills or a 30 day supply)	**ESI by Mail** (Up to a 90-day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Single-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Non-Select Specialty Medication Out-of-Pocket Maximum per Calendar Year	Does not apply		$1,500 per individual / $3,000 per family
Select Specialty Medications (Co-payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.04.

INSURED BENEFITS	CARRIER
▯ Dental Benefits	Delta Dental of Illinois
▯ Vision Benefits	Vision Service Plan of Illinois (VSP)
▯ Life Insurance Benefit ($25,000, Retirees Under Age 65 Only)	The Hartford

Appendix C

SCHEDULE OF BENEFITS
FOR THE LOW COST MEDICAL PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Low Cost Medical Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). Except as required by law for Protected Services, R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	70% paid by Plan	50% paid by Plan
	Protected Services and Continuing Care Services are payable at the PPO provider rate.	
Deductible per Calendar Year	$600 per Covered Individual / $1,800 per family	
Out-of-Pocket Maximum per Calendar Year	$4,600 per Covered Individual / $9,200 per family (includes Deductible)	
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible covered services for the remainder of the Calendar Year. Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
Acupuncture Care	See *Chiropractic, Acupuncture and Naprapathic Care, page App C-2*	
Ambulance Service	70% paid by Plan subject to the PPO Deductible	
Anesthesia or Sedation	70% paid by Plan	50% paid by Plan
Bariatric Surgery (only for the diagnosis and treatment of morbid obesity)	70% paid by Plan	50% paid by Plan
	Prior to surgery, a Covered Individual is required to contact the Fund Office to enroll in and successfully complete ComPsych's Bariatric Support Service Program (BSSP). Participation in the BSSP is mandatory for coverage.	
Behavioral Health Care	See page App. C-5	
Breast Feeding Support and Equipment to the extent required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)	70% paid by Plan	50% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year. No coverage for Dependent children	
Clinical Trials to the extent required by the Affordable Care Act	70% paid by Plan	50% paid by Plan
	See Plan Section 5.04(H)	
Contraceptives to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
Cosmetic Surgery solely to improve appearance	No coverage	
Dental Service for a Non-Occupational Injury to Teeth	No coverage	
Diagnostic Imaging Benefit MRI, CAT/CT and PET Scans	70% paid by Plan	50% paid by Plan
Diagnostic X-Rays and Lab Tests	70% paid by Plan	50% paid by Plan
Durable Medical Equipment	70% paid by Plan	50% paid by Plan
Emergency Services	70% paid by Plan	70% paid by Plan
o Facility fees o Physician fees	70% paid by Plan	70% paid by Plan
Emergency Room Co-payment	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
Extended Care/Skilled Nursing Facility	70% paid by Plan	50% paid by Plan
	Maximum of 120 days per convalescent period	
Genetic Testing Benefit		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	50% paid by Plan Subject to Calendar Year Deductible, Subject to Out-of-Pocket Maximums and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	70% paid by Plan	50% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage
Hearing Benefit	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
Home Health Care	70% paid by Plan	50% paid by Plan
	Maximum of 120 visits per year	

	BCBS PPO Provider	Out-of-Network Provider
Hospice Care	70% paid by Plan	50% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
Hospital Care	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
Infertility Services including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing which may be covered above	70% paid by Plan	50% paid by Plan
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse. No coverage for dependent children.	
Infusion Therapy for the administration of an intravenous prescription drug	70% paid by Plan	50% paid by Plan
Member Assistance Program	See page App. C-5	
Naprapathic Care	See *Chiropractic, Acupuncture and Naprapathic Care*, page App C-2	
Nutritional Counseling to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
Oral and Maxillofacial Surgery	70% paid by Plan	50% paid by Plan
Organ Transplant	70% paid by Plan	50% paid by Plan
Physician Services	70% paid by Plan	50% paid by Plan
Pregnancy Care	70% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Deductible does not apply.	50% paid by Plan
Prosthetics o Artificial limbs and eyes	70% paid by Plan	50% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	No coverage	
Reconstructive Breast Surgery	70% paid by Plan	50% paid by Plan
Sterilization o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No Coverage
o Males	70% paid by Plan	No Coverage
o Sterilization reversals (female/male)	No Coverage	No Coverage
Substance Use Disorder	See page App. C-5	
Surgi-Center Facility o Hospital Affiliated	70% paid by Plan	50% paid by Plan
o No Hospital Affiliation	70% paid by Plan	No coverage
Surgical Assistant or Assistant Surgeon	70% paid by Plan	50% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
Surgical Consultations	70% paid by Plan	50% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
▯ **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	70% paid by Plan	50% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	70% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
▯ **Therapy Services** o **Physical and Speech Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
o **Occupational Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
o **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	70% paid by Plan	50% paid by Plan
▯ **Urgent/Immediate Care Facilities and Retail Clinics**	70% paid by Plan	50% paid by Plan
▯ **Vision Surgery** (excluding cosmetic or refractive corrections)	70% paid by Plan	50% paid by Plan
▯ **Wellness and Preventive Care** o **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Participant and spouse once every Calendar Year. Calendar Year Deductible does not apply. No coverage for Dependent children	

HEALTH CENTER For Eligible Covered Individuals Only	
▯ **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out of Network Provider**
▯ **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year. Calendar Year Deductible does not apply.	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS In-Network Provider[2]	**Out of Network Provider**
Emergency Services	70% paid by Plan	70% paid by Plan
o Facility	70% paid by Plan	70% paid by Plan
o Physician fees		
Emergency Room Co-payment	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
Hospital Care and Residential Treatment Facilities	70% paid by Plan	50% Paid by Plan
	Confinement maximum: 180 days per calendar year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
Hospital Outpatient Diagnostic Tests	70% paid by Plan	50% paid by Plan
Outpatient Therapy (Including Partial Hospitalization)	70% paid by Plan	50% paid by Plan
Custodial or Group Homes	No coverage	

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	70% paid by Plan		Does not apply
Single-Source Brand Co-payment (A generic is not available)	70% paid by Plan		Does not apply
Multi-Source Brand Co-payment (A generic is available)	70% paid by Plan		Does not apply
Non-Select Specialty Medication Co-payment (Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		70% paid by Plan
Select Specialty Medications (Co-Payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.03.

[2] Lyra Health providers may also qualify as Network Providers to the extent they provide services under the Plan's Health Plan Integration Program.

LIFE INSURANCE BENEFITS Contracted Provider: Self-Funded			
	Eligible Participant	**Spouse**	**Child**
Policy amount	$5,000	$1,000	$1,000

EXCLUDED BENEFITS	
Vision Benefits	No coverage
Dental Benefits	No coverage
Short Term Disability Benefits	No coverage
Accidental Death and Dismemberment Insurance Benefits	No coverage

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its November 30, 2022 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS the Trustees desire to amend the Plan to clarify certain aspects of the Plan's Retiree eligibility rules and to expand the instances in which baby formula is covered;

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 7, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — 11/30/2022 — Date

Gerald W. Thiel, Jr., Secretary — 11/30/2022 — Date

EXHIBIT A

AMENDMENT NO. 7 TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN DOCUMENT
(RESTATED EFFECTIVE DECEMBER 1, 2020)

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective July 1, 2023, Article III, Eligibility, Section 3.03(A)(5) is amended to read:

Section 3.03 Eligibility for Retirees and Certain Eligible Dependents

(5) Commenced receiving pension benefits from the Will County Local 174 Carpenters Pension Fund on or after January 1, 2019 with a pension based on at least ten (10) years of Eligibility Service. If at some time the Participant did not earn Eligibility Service for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of Eligibility Service. A participant who received a disability benefit continuously through his pension benefit commencement date will be eligible for the Retiree Plan provided that the participant satisfied all of the aforementioned Retiree Plan eligibility requirements on the date the participant's disability benefit commenced. For purposes of this Plan Section 3.03(A)(5) and Plan Section 3.07, Eligibility Service shall include:

(a) The total years of past service credit earned prior to June 1, 1961 by Employees under the Will County Local 174 Carpenters Pension Plan, will be counted as Eligibility Service.

(b) Hours of service earned on or after June 1, 1961 by Employees under the Will County Local 174 Carpenters Pension Fund within a Plan Year, as defined by the Will County Local 174 Carpenters Pension Plan, will be counted as Eligibility Service in the following manner:

Hours of Service under the Will County Local 174 Carpenters Pension Fund within a Plan Year	Fractional Years of Eligibility Service
Less than 250	Zero
250 but less than 500	.25 year
500 but less than 750	.50 year
750 but less than 1,000	.75 year
1,000 or more	1.0 year

(c) Years of Eligibility Service, as determined by the above chart, will be considered to have been earned during the Calendar Year in which the Plan Year of the Will County Local 174 Carpenters Pension Fund ended.

2. Effective July 1, 2023, Article III, Eligibility, Section 3.05(C)(3) is amended to read:

Section 3.05 Enrollment for Retiree Plan of Benefits

(C) Special Enrollment in the Retiree Plan of Benefits:

(3) If a Retiree did not enroll himself and/or any Dependents when the Retiree and/or Dependent first became eligible for such coverage under the Plan due to existing coverage from an Outside Plan or Medicaid, the Retiree and his Dependents will only be allowed to enroll at a later date if the Retiree provides proof of creditable coverage from an Outside Plan. Creditable coverage dates must be continuous from the pension start date to the date of enrollment in the Retiree Plan or, if shorter, the three-year period immediately preceding his enrollment in the Retiree Plan. However, a Retiree and/or any Dependents may have one (1) or more gaps in continuous creditable coverage provided the gap(s) in coverage do not exceed one hundred and five (105) days in the aggregate and the Retiree and/or Dependent has coverage under an Outside Plan or Medicaid at the time of his enrollment in the Retiree Plan. A Dependent may only enroll if the Retiree is enrolled. The Retiree must request the required enrollment form(s) from the Fund Office. The completed enrollment form(s) must be returned to the Fund Office along with the same required supporting documentation as listed in Plan Section 3.16(G) for the Active Plan of Benefits no later than ninety (90) days after the termination of the Outside Plan or Medicaid coverage to enable Retiree Plan eligibility to commence coincident with the loss of the Outside Plan or Medicaid coverage. These enrollment rights and obligations shall also apply to surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria of Plan Section 3.03(C).

3. Effective July 1, 2023, Article III, Eligibility, Section 3.07(A)(10) is amended to read:

Section 3.07 Premium Payments for Retiree Coverage

(10) For a period of at least three (3) years after the merger date of December 31, 2018 ("Grandfather Period"), Will County Local 174 Carpenters Pension Fund Retirees who commenced receiving pension benefits on or before December 1, 2018 ("Merging Fund Retirees") will be subject to the applicable premerger premium rates for comprehensive medical and prescription drug benefits, but must pay the separate monthly premium applicable under this Plan for dental and vision benefits. If a Merging Fund Retiree s coverage is cancelled, either voluntarily, due to non-payment of a required premium, or due to a suspension of the Retiree s pension benefit, and if the Merging Fund Retiree subsequently re-enrolls in coverage during the Grandfather Period, the Merging Fund Retiree shall remain subject to these same premium rules during the Grandfather Period. These same rules apply to Dependents and surviving spouses of Merging Fund Retirees during the Grandfather Period, as well as participants receiving a disability benefit who commence receiving pension benefits during the Grandfather Period.

4. Effective January 1, 2023, Article III, Eligibility, Sections 3.07(F) and (G) are amended to read:

Section 3.07 Premium Payments for Retiree Coverage

(F) The Retiree, the Retiree's surviving spouse or the Retiree's Dependent must notify the Fund Office of the death of a Dependent, or the Dependent's termination of status as a Dependent on a timely basis so that coverage for the Dependent can be terminated. If the Retiree or the Retiree's surviving spouse was paying a premium for the Dependent's coverage and the Dependent's coverage is terminated, no premiums will be refunded for any period exceeding twelve (12) months in which the required notice is not given.

(G) The Retiree, the Retiree's Dependent, or the Retiree's surviving spouse (and any surviving Dependents) who are eligible pursuant to Plan Section 3.03(C) must submit a copy of his Medicare card to the Fund Office as soon as he receives it from Medicare. Comprehensive Medical Benefit premiums will not be refunded for any period exceeding twelve (12) months.

5. Effective January 1, 2023, Article III, Eligibility, Section 3.13(A)(2) is amended to read:

Section 3.13 Termination of Eligibility under the Retiree Plan

(2) The last day of the month prior to the month in which the Retiree's pension benefit is suspended due to a recovery from Disability or a return to work in prohibited employment as defined by the applicable Pension Plan. In the event a Retiree's Pension Plan benefit is suspended to address prior periods that the Retiree was engaged in prohibited employment, then the Retiree's eligibility under the Retiree Plan shall be terminated for each month the Retiree's benefit is suspended under the applicable Pension Plan. The Fund shall notify the Retiree in advance before terminating the Retiree's eligibility under the Retiree Plan.

6. Effective January 1, 2023, Article III, Eligibility, Section 3.13(C) is amended to read:

Section 3.13 Termination of Eligibility under the Retiree Plan

(C) A Retiree who engages in prohibited employment as defined by the applicable Pension Plan (including Retirees whose Pension Plan benefits are suspended based on work in prohibited employment discovered after the prohibited employment commences) or recovers from a Disability is no longer eligible for Retiree Plan coverage. The Retiree and Dependents may be offered a conversion policy on a self-pay basis through the Contracted Provider to the extent permitted by the Insurance Company. This conversion coverage may not be the same coverage provided by the Plan and a conversion fee may apply. However, a Retiree who returns to Covered Employment will be eligible for Active Plan coverage if he satisfies the eligibility requirements of Plan Section 3.01.

7. Effective May 1, 2022, Article VIII, Prescription Drug Benefits, Section 8.06(P) is amended to read:

Section 8.06 Prescription Drug Exclusions

(P) Vitamins, food supplements, infant formulas or homeopathic drugs, except to the extent eligible under Plan section 13.01(N);

8. Effective May 1, 2022, Article XIII, Plan Exclusions and Limitations, Section 13.01(N) is amended to read:

Section 13.01 General

(N) Food supplements or baby formulas, unless: (1) administered through a feeding tube or (2) orally with the diagnosis of eosinophilic gastroenteritis, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, methylmalonic acidemia, urea cycle disorders, phenylketonuria, Crohn's disease, ulcerative colitis, gastrointestinal dysmotility, gastroesophageal reflux, chronic intestinal pseudo-obstruction, or other organic and amino acidemias.

9. Effective July 1, 2023, Article XIV, Coordination of Benefits, Section 14.03(C) is amended to read:

Section 14.03 Coordination of Benefits with Medicare under the Retiree Plan of Benefits

(C) For Retirees and their Dependents, as of the first day of the month in which they attain age 65, this Plan will take Medicare Part A and Medicare Part B benefits into account when coordinating coverage under the Coordination of Coverage provisions, whether or not the Covered Individual enrolls in Medicare or is eligible to enroll in Medicare.

10. Effective July 1, 2023, Article XIV, Coordination of Benefits, Section 14.05 is amended to read:

Section 14.05 Coordination of Benefits with Medicare Replacement Plans for the Retiree Plan of Benefits

For Covered Individuals enrolled in a Medicare Replacement Plan (such as Medicare Advantage or Medicare Part C) this Plan remains secondary. The Covered Individual must follow the rules of the Medicare Replacement Plan, including seeking services from that plan's participating provider and this Plan will coordinate coverage with such Medicare Replacement Plan as if the services were covered under Medicare Parts A and B (regardless of whether the Covered Individual has taken action to obtain such coverage or is eligible for such coverage).

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its February 22, 2023 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS the Trustees desire to amend the Plan to reflect various updates;

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 8, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — Date: 2-22-23

Gerald W. Thiel, Jr., Secretary — Date: 2/22/2023

EXHIBIT A

AMENDMENT NO. 8 TO THE MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN DOCUMENT (RESTATED EFFECTIVE DECEMBER 1, 2020)

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective January 1, 2023, Article II, Definitions, Section 2.32 is amended to read:

Section 2.32 Dependent

"Dependent" means any of the following individuals:

(A) 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;

(B) The Participant's biological child through the end of the calendar month in which the child attains age twenty-six (26);

(C) The Participant's adopted child or child placed for adoption in the Participant's home for legal adoption (before attaining the age of twenty-six (26)) through the end of the calendar month in which the child attains age twenty-six (26); or

(D) The Participant's biological or adopted child with a physical or mental disability who is unmarried and age twenty-six (26) or older if:

(1) The child was covered by the Plan upon reaching age twenty-six (26);

(2) The disability is considered permanent and began prior to the child attaining age twenty-six (26), while the child was covered as a Dependent under this Plan, unless the disability began at birth and the Dependent was covered under this Plan for at least five (5) consecutive years prior to the Dependent turning age 26, and proof of such is provided to the Fund Office;

(3) The child is chiefly dependent on the Participant for more than fifty percent (50%) of the child's financial support and maintenance during the Calendar Year and proof of such is provided to the Fund Office;

(4) The disability is a severe physical or mental impairment that causes the child to be incapable of self-support; and

(5) The child qualifies as the Participant's "qualifying child" or "qualifying relative" within the meaning of Internal Revenue Code Section 152(c) or (d).

The Trustees may periodically require that the Participant produce evidence to support that a child satisfies these criteria and can terminate a child's Dependent status if satisfactory evidence is not timely produced.

(E) The Participant's unmarried stepchild (a) through the end of the calendar month in which the child attains age twenty-six (26), who is in a regular parent-child relationship with the Participant and who resides with the Participant for more than one-half (1/2) of the Calendar Year and who is chiefly dependent on the Participant for more than fifty percent (50%) of his financial support and maintenance during the Calendar Year and proof of such is provided to the Fund Office. A stepchild must be a child of the Participant's current spouse who was born to the spouse or legally adopted by the spouse before the marriage to the Participant. Solely for purposes of the Plan's disability extension as described in Plan Section 2.30(D), the requirement that the stepchild reside with the Participant for more than one-half the Calendar Year shall not apply. Primary coverage for a stepchild is provided only in the event that no other person is obligated to provide health coverage; and no other coverage is available through the biological parents; (b) is physically or mentally disabled and age twenty-six (26) or older, if:

(1) The stepchild was covered by the Plan upon reaching age twenty-six (26);

(2) The disability is considered permanent and began prior to the stepchild attaining age twenty-six (26), while the stepchild was covered as a Dependent under this Plan, unless the disability began at birth and the Dependent was covered under this Plan for at least five (5) consecutive years prior to the Dependent turning age 26, and proof of such is provided to the Fund Office;

(3) The disability is a severe physical or mental impairment that causes the child to be incapable of self-support; and

(4) The stepchild qualifies as a "qualifying child" or "qualifying relative" of the Participant within the meaning of Internal Revenue Code Section 152(c) or (d);

(F) A Participant's eligible child named as a dependent under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice.

(G) A minor Dependent child is a child from birth through age eighteen (18). An adult Dependent child is a child age nineteen (19) to age twenty-six (26).

2. Effective January 1, 2023, Article II, Definitions, is amended to add a new Section 2.78, Private-Duty Nursing, to read as follows. All subsequent sections and cross references are renumbered accordingly.

Section 2.78 Private Duty Nursing

"Private Duty Nursing" means skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing

is shift nursing and does not include nursing care of less than 8 hours per day. Private Duty Nursing does not include Custodial Care.

3. Effective January 1, 2023, Article II, Definitions, Section 2.92 is amended to read:

Section 2.92 Room and Board Charges

"Room and Board Charges" means charges made by a Hospital, an Extended Care/Skilled Nursing Facility, or a Hospice Facility, on its own behalf for room and board at a semi private room rate, general duty nursing (including Private Duty Nursing to the extent Medically Necessary, not to exceed eight hours per day and limited to 120 visits per calendar year), and any other charges that are regularly made by the Hospital or facility as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of a Physician. Such charges are based on a confinement or stay of twenty-four (24) hours or any shorter period for which the Hospital or facility regularly charges a full day's room and board rate.

4. Effective January 1, 2023, Article III, Eligibility for Different Type of Retiree Coverage, Section 3.04(C) is amended to read:

Section 3.04 Eligibility for Different Type of Retiree Coverage

(C) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A)(6) and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are eligible for Medicare are eligible to enroll in the following coverage options; however, a Dependent may only enroll in the coverage options that the Retiree is enrolled in:

(1) The prescription drug benefits, as described in Article VIII and Appendix B; and/or

(2) The Medicare Part A Supplemental Hospital coverage as described in Article V, Plan Section 5.04(U) and Appendix B (effective January 1, 2023, Retirees and Dependents enrolled in this option were automatically enrolled in the Medicare Parts A and B Supplemental coverage described in Plan Section 3.03(B)(2) and this option was terminated); and/or

(3) Dental benefits as described in Article VII and Appendix B; and/or

(4) Vision benefits as described in Article VI and Appendix B.

5. Effective January 1, 2023, Article III, Premium Payments for Retiree Coverage, Section 3.07(B) is amended to read:

Section 3.07 Premium Payments for Retiree Coverage

(B) Premiums for Retirees and their Dependents or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) where the Retiree has a pension annuity starting date of June 1, 2006 or earlier will be determined based on the following:

(1) Covered Individuals eligible for Medicare Parts A and B Supplemental coverage and prescription drug benefits must pay a separate monthly premium for Medicare Parts A and B Supplemental coverage and for the prescription drug benefits, except Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(2) Covered Individuals eligible for Medicare Part A Supplemental Hospital coverage and prescription drug benefits must pay a separate monthly premium for Medicare Part A Supplemental Hospital coverage and for the prescription drug benefits except Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit; effective January 1, 2023, the Medicare Part A Supplemental Hospital coverage option was terminated, and Retirees and Dependents that were participating in this option became eligible for Medicare Parts A and B Supplemental coverage, and the applicable monthly premium under Plan section 3.07(B)(1).

(3) Covered Individuals eligible for prescription drug benefits must pay a monthly premium for the prescription drug benefit except Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(4) Each Covered Individual must pay a separate monthly premium for dental benefits. The monthly premium rates for dental benefits are determined by the Insurance Company.

(5) Each Covered Individual must pay a separate monthly premium for vision benefits. The monthly premium rates for vision benefits are determined by the Insurance Company.

(6) Premiums for surviving spouses (and any surviving Dependents) added by the Retiree after June 1, 2006 will be subject to the tiered premiums as described in Plan Section 3.07(A).

6. Effective January 1, 2023, Article V, Covered Services and Exclusions, Section 5.04(S) is amended to read:

Section 5.04 Covered Services and Exclusions

(S) Home Health Care:

The Plan covers home health services and supplies in a Covered Individual's home when ordered by a treating Physician and services are provided by a Home Health Agency in order to obtain a specified medical outcome. Each house call made by a member of the home health care team counts as one (1) visit. Each house call up to four (4) hours made by a home health aide also counts as one (1) visit. However, if all visits are performed on the same day, by the same agency, they count as only one (1) visit. The following apply:

(1) Medically Necessary home health services provided in a Covered Individual's residence as an appropriate cost-effective alternative to care in another health care setting (*e.g.*, inpatient hospital, inpatient skilled nursing facility, long term care facility) include:

(a) Physical, occupational, respiratory and speech therapy when used to restore loss of an established function caused by an Illness or Injury;

(b) Medical supplies, DME, prescription drugs and medicines, enteral feeding, diagnostic x-ray and laboratory tests for services if these services and supplies would have been covered had the Covered Individual been confined in a Hospital or Convalescent Facility;

(c) Skilled nursing care on a part-time or intermittent basis, including services and care that can only be performed safely and effectively by a licensed nurse (either a registered nurse or licensed practical nurse), licensed vocational nurse or another provider acting within the scope of the provider's license, including Private Duty Nursing (to the extent Medically Necessary, not to exceed eight hours per day and limited to 120 visits per calendar year); and

(d) Medical social services, under the direction of a Physician.

(2) A prescribed Treatment Plan outlining the treatment goals must be submitted with the request for specific services and supplies. Periodic review of the prescribed Treatment Plan and progress towards those goals may be required for continued skilled nursing care needs.

(3) The Plan excludes the following:

(a) Twenty-four (24) hours a day home health care;

(b) Home delivery of meals;

(c) Homemaker services such as shopping, cleaning, and laundry when this is the only care needed and when these services are not related to a Covered Individual's Treatment Plan;

(d) Custodial care, domiciliary care, respite care, rest cures or personal care given by a home health aide such as bathing, dressing, and using the bathroom when this is the only care provided.

7. Effective September 1, 2022, Article V, Covered Services and Exclusions, Section 5.04(Z) is amended to read:

Section 5.04 Covered Services and Exclusions

(Z) Nutritional Counseling:

(1) The Plan covers the following nutritional counseling on limited basis when prescribed by a Physician:

(a) To the extent required under the Affordable Care Act for the diagnosis of obesity, diabetes, cardiovascular and kidney disease;

(b) For Covered Individuals who participate in the bariatric program maintained by the Contracted Provider;

(c) For treatment of eating and gastrointestinal disorders; cardiovascular, kidney, chronic obstructive pulmonary diseases; diabetes; hypertension; seizures; and cancer.

The services can be provided by a registered dietician, a Medicare-approved nutrition professional or, as appropriate, by another provider acting within the scope of the provider's license.

(2) The Plan excludes nutritional counseling for conditions other than those stated above.

8. Effective January 1, 2023, Article XI, Beneficiary Designation for Life Insurance Benefits, Section 11.04(C) is amended to read:

Section 11.04 Beneficiary Designation for the Life Insurance Benefit

(C) Any amount payable to a beneficiary by the Insurance Company for the Active Plan or by the Health Fund for the Low Cost Medical Plan will be paid to the beneficiary or beneficiaries designated by the Employee in accordance with the following rules:

(1) If more than one (1) beneficiary is designated, the designated beneficiaries will share equally unless the Employee stipulates otherwise on the beneficiary designation form;

(2) If any designated beneficiary dies before the Employee, the share that such beneficiary would have received if he had survived the Employee's death will be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survive the Employee; and

(3) If no designated beneficiary survives the Employee, or if no beneficiary has been designated, payment will be made according to the laws of inheritance in the signatory State, which generally run in the following order:

(a) The Employee's estate;

(b) The Employee's surviving spouse;

(c) If no spouse survives the Employee, in equal shares to the biological and adoptive children who survive the Employee;

(d) If no spouse or biological or adoptive children survive the Employee, to the Employee's living parents equally, or to the surviving parent.

9. Appendix B is amended and restated in its entirety to read as set forth in the attached Exhibit I.

EXHIBIT I

Appendix B

SCHEDULE OF BENEFITS FOR THE RETIREE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Retiree Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C allowance). Except as required by law for Protected Services, R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
	Protected Services and Continuing Care Services are payable at the PPO provider rate.	
Deductible per Calendar Year	$300 per Covered Individual $600 per family	$600 per Covered Individual
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family (includes deductible)	$6,000 per Covered Individual
	After a Covered Individual satisfies the deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO deductibles and Out-of-Pocket Maximums are separate and cannot be combined. Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit), see page App B-2*	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	80% paid by Plan	60% paid by Plan
	A Covered Individual is required to contact BCBSIL before any treatment is given and must be approved for surgery.	
• **Behavioral Health Care**	See page App. B-5	

• **Breast Feeding Support and Equipment** as required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
• **Contraceptives,** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	80% paid by Plan	60% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Services** o Facility o Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Hearing Benefit** o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)	
oHearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)** / **BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply	
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply	
	BCBS PPO Provider	**Out-of-Network Provider**
• **Home Health Care**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Hospice Care**	80% paid by Plan	60% paid by Plan
	Lifetime maximum of 180 days per individual	
• **Hospital Care**	80% paid by Plan	60% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing, which may be covered above	80% paid by Plan	60% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App B-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No Coverage
• **Oral and Maxillofacial Surgery**	80% paid by Plan	60% paid by Plan
• **Organ Transplant**	80% paid by Plan	60% paid by Plan
• **Physician Services**	80% paid by Plan	60% paid by Plan
• **Pregnancy Care**	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan
• **Prosthetics** o Artificial limbs and eyes	80% paid by Plan	60% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum Calendar Year Deductible does not apply	
• **Reconstructive Breast Surgery**	80% paid by Plan	60% paid by Plan

	BCBS In-Network Provider	Out-of-Network Provider
• **Sterilization**		
o Females to the extent required under the Affordable Care Act	100% paid by Plan, Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See Page App. B-5	
• **Surgi-Center Facility**		
o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ)		
o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services**		
o **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Covered Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE	
• **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS In-Network Provider	**Out-of-Network Provider**
• **Emergency Services** oFacility	80% paid by Plan	80% paid by Plan
oPhysician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours. Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement Maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN HOSPITAL BENEFITS ONLY AS DESCRIBED IN PLAN SECTION. 5.04(U) **Per Benefit Period (Benefit Option Terminated January 1, 2023)*** ***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.** Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)	
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)**	**Plan Pays secondary to Medicare** **Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible

o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 days	Plan pays 100% of Medicare eligible expenses

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS Per Benefit Period*

***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.**

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)***	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
o First 60 days	Plan pays Medicare Part A Deductible
o 61st through 90th days	Plan pays Medicare Part A Co-payment
o 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
o Additional 365 Days	Plan Pays 100% of Medicare eligible expenses
• **Medicare Part B Supplement**	
o Medicare Part B Deductible	Plan pays Medicare Part B Deductible
o Medical expenses	Plan pays 20% of Medicare eligible expenses at the Medicare approved amount, after the Medicare Part B Deductible
• **Blood**	Plan pays for three (3) pints
• **Skilled Nursing Facility Care*** - Covered Individual must meet Medicare's requirements, including having been in a Hospital for at least three days and enter a Medicare approved facility within 30 days of leaving the Hospital	
o First 20 days	Medicare pays all approved amounts
o 21st through 100th day	Plan pays Medicare Part A Co-Payment
• **At Home Recovery Services Not Covered by Medicare** – Home care certified by a Covered Individual's Doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home treatment plan.	
o Benefit for each visit	Plan pays up to $40 per visit (Private Duty Nursing covered up to number of Medicare-approved visits, not to exceed 7 visits per week) Up to a Calendar Year Maximum of $1,600
• **Foreign Travel**	
o Calendar Year Deductible	$250 per Covered Individual
	Plan pays 80%. The Plan does not pay for expenses in excess of the Reasonable and Customary Allowance for non-PPO Out-of-Network providers. Amounts over the Reasonable and Customary Allowance are the Covered Individual's responsibility
o Lifetime Maximum for Foreign Travel	$50,000

• **Hearing Benefit** o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
oHearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply		

➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

PRESCRIPTION BENEFIT

Contracted Network Provider: Express Scripts, Inc. (ESI) and Accredo Specialty Pharmacy

Not available to Deferred Lathers or to Medicare-eligible individuals with Medicare Part D coverage.

	ESI Network Retail Pharmacy (Lesser of 100 pills or a 30 day supply)	**ESI by Mail** (Up to a 90-day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Single-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Non-Select Specialty Medication Out-of-Pocket Maximum per Calendar Year	Does not apply		$1,500 per individual / $3,000 per family
Select Specialty Medications (Co-payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.04.

INSURED BENEFITS	CARRIER
• Dental Benefits	Delta Dental of Illinois
• Vision Benefits	Vision Service Plan of Illinois (VSP)
• Life Insurance Benefit ($25,000, Retirees Under Age 65 Only)	The Hartford

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its November 29, 2023 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS the Trustees desire to amend the Plan to eliminate the eight-hour minimum shift from the Private Duty Nursing definition and the eight-hour maximum from the Room and Board Charges definition.

WHEREAS the Trustees desire to amend the Plan to provide gender affirming care coverage.

WHEREAS the Trustees desire to amend the Plan to include additional covered services in the Centers of Health benefit.

WHEREAS the Trustees desire to amend the Plan to provide Omnipod coverage under the prescription drug program.

WHEREAS the Trustees desire to amend the Plan to reflect the order of payment of life insurance death benefits consistent with the terms of the insurance policy in effect at the time of death.

WHEREAS the Trustees desire to amend the Plan to remove the COVID-19 temporary relief coverage.

WHEREAS the Trustees desire to amend the Plan to reflect that coverage for Medicare-eligible participants will be provided through an insured MAPD, and to eliminate the Medicare supplement benefit.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 9, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — 11/29/23 Date

Gerald W. Thiel, Jr., Secretary — 11/29/23 Date

AMENDMENT NO. 9
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective July 30, 2021, Article V, Carpenters Center for Health Benefits, Section 5.05(C), "Scope of Services" is amended to add three additional services:

(12) Physical therapy;

(13) Chiropractic services; and

(14) Behavioral Health counseling.

2. Effective January 1, 2023, Article V, Comprehensive Medical Benefits, section 5.04, "Covered Services and Exclusions," is amended to add a new subsection (QQ) to read as follows:

(QQ) Gender Affirming Services:

Benefits are payable for gender affirming services consistent with the guidelines of the Plan's Contracted Provider. Prior authorization is required.

3. Effective January 1, 2023, Article XIII, Plan Exclusions and Limitations, Section 13.01, "General" is amended to delete subsection (S) and replace it with "reserved".

4. Effective January 1, 2023, Article VIII, Prescription Drug Benefits, section 8.01 "Covered Services" is amended to add a new subsection (G) to read as follows:

(G) The Plan covers Omnipod brand tubeless insulin pumps.

5. Effective May 11, 2023, Article XX, COVID-19 Temporary Relief, is deleted in its entirety.

6. Effective July 1, 2023, Article XI, Life Insurance Benefits, Section 11.04, "Beneficiary Designation for the Life Insurance Benefit," subsection (C)(3) is amended to read:

(3) If no designated beneficiary survives the Employee, or if no beneficiary has been designated, payment will be made consistent with the terms of the life insurance policy in effect at the time of death. As of July 1, 2023, the terms of the life insurance policy provide that payment will be made in the following order:

(a) The Employee's surviving spouse;

(b) If no spouse survives the Employee, in equal shares to the Employee's surviving biological or adopted children:

(c) If no spouse or children survive the Employee, in equal shares to the Employee's surviving parents, or to the surviving parent;

(d) If no spouse, children or parents survive the Employee, in equal shares to the Employee's surviving brothers and sisters;

(e) If no spouse, children, parents or siblings survive the Employee, to the Employee's estate.

7. Effective January 1, 2024, Article II, Definitions, section 2.56, "Insurance Company" is amended to read as follows:

> "Insurance Company" means the Contracted Providers providing the MAPD Benefit, Retiree Plan of Benefits Dental Care Benefit described in Article VII, Vision Benefits as described in Article VI, Life Insurance as described in Article XI and Accidental Death and Dismemberment Benefits as described in Article XII.

8. Effective January 1, 2024, Article II, Definitions, is amended to add a new section 2.61 to read as follows:

> **Section 2.61 MAPD Benefit**
>
> "MAPD Benefit" means the Plan's Medicare Advantage and Prescription Drug benefit, including dental. The MAPD Benefit is fully insured by the Plan's Contracted Provider. The insurance policy, a copy of which is on file with the Administrator, incorporated into the Plan by reference.

The remainder of the sections in Article II and all cross references are renumbered and updated accordingly.

9. Effective January 1, 2024, Article II, Definitions, section 2.79 (formerly 2.78) "Private Duty Nursing" is amended to read:

> "Private Duty Nursing" means skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing is shift nursing and does not include Custodial Care.

10. Effective January 1, 2024, Article II, Definitions, section 2.93 (formerly 2.92) "Retiree Plan or Retiree Plan of Benefits" is amended to read:

> "Retiree Plan" or "Retiree Plan of Benefits" means the benefits described in this Plan and in the Schedule of Benefits as described in Appendix B and the MAPD Benefit for Covered Individuals who maintain eligibility under this Plan.

11. Effective January 1, 2024, Article II, Definitions, section 2.94 (formerly 2.93) "Room and Board Charges" is amended to read:

"Room and Board Charges" means charges made by a Hospital, an Extended Care/Skilled Nursing Facility, or a Hospice Facility, on its own behalf for room and board at a semi private room rate, general duty nursing, Private Duty Nursing to the extent Medically Necessary, limited to 120 visits per calendar year, and any other charges that are regularly made by the Hospital or facility as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of a Physician. Such charges are based on a confinement or stay of twenty-four (24) hours or any shorter period for which the Hospital or facility regularly charges a full day's room and board rate.

12. Effective January 1, 2024, Article III, Eligibility, section 3.04, "Eligibility for Different Types of Retiree Coverage," is restated in its entirety to read as follows:

(A) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A), Paragraphs 1 thru 5, and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are not Medicare eligible are eligible to enroll in the following coverage options; however, a Dependent may only enroll in the coverage options that the Retiree is enrolled in:

(1) The prescription drug benefit, as described in Article VIII and Appendix B, except Deferred Lathers are not eligible for the prescription drug benefit; and comprehensive medical benefits as described in Article V and Appendix B; and/or

(2) Dental benefits as described in Article VII and Appendix B; and/or

(3) Vision benefits as described in Article VI and Appendix B.

Retirees who retired prior to January 1, 2024 can separately elect prescription drug benefit and/or comprehensive medical benefits in addition to dental and/or vision benefits. However, Will County Local 174 Carpenters Welfare Fund retirees who retired on December 1, 2018 or earlier must elect and maintain both the prescription drug and comprehensive medical benefits under this Plan Section 3.04(A)(1) and (2), but have the option of separately electing dental or vision benefits.

(B) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A), Paragraphs 1 thru 5, and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are eligible for Medicare are eligible to enroll in the following coverage options; however, a Dependent may only enroll in the coverage options that the Retiree is enrolled in:

(1) The MAPD Benefit; and/or

(2) Dental benefits as described in Article VII and Appendix B; and/or

(3) Vision benefits as described in Article VI and Appendix B.

Will County Local 174 Carpenters Welfare Fund retirees who retired on December 1, 2018 or earlier must elect and maintain the MAPD Benefit, but have the option of separately electing dental or vision benefits.

(C) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A)(6) and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are eligible for Medicare are eligible to enroll in the following coverage options; however, a Dependent may only enroll in the coverage options that the Retiree is enrolled in:

(1) The MAPD Benefit; and/or

(2) Dental benefits as described in Article VII and Appendix B; and/or

(3) Vision benefits as described in Article VI and Appendix B.

(D) Medicare Retirees who were enrolled in only the Medicare Parts A and B Supplemental coverage on December 31, 2023 will be automatically enrolled into the MAPD Benefit effective January 1, 2024 unless the Retiree elects to opt-out of coverage. Medicare Retirees who were enrolled in only the prescription drug benefit on December 31, 2023 will be offered a one-time election to enroll into the MAPD Benefit effective January 1, 2024. If such Retiree does not elect MAPD Benefit coverage, prescription drug coverage will terminate effective January 1, 2024.

13. Effective January 1, 2024, Article III, Eligibility, section 3.06, "Effective Date of Retiree and Survivor Coverage," is amended to add a new subsection (H) to read as follows:

(H) Notwithstanding anything to the contradictory above, for Retirees and surviving dependents eligible for the MAPD Benefit, coverage will become effective pending approval from the Contracted Provider.

14. Effective January 1, 2024, Article III, Eligibility, section 3.07, "Premium Payments for Retiree Coverage," is amended to revise subsection (B)(1) as follows, to delete subsection (B)(2) and to renumber the remaining subsection accordingly:

(1) Covered Individuals eligible for MAPD Benefit must pay a separate monthly premium for the MAPD Benefit.

15. Effective January 1, 2024, Article V, Comprehensive Medical Benefits, section 5.04, "Covered Services and Exclusions," subsection (S)(1)(c) is revised to read as follows:

> (c) Skilled nursing care on a part-time or intermittent basis, including services and care that can only be performed safely and effectively by a licensed nurse (either a registered nurse or licensed practical nurse), licensed vocational nurse or another provider acting within the scope of the provider's license; including Private Duty Nursing (to the extent Medically Necessary, limited to 120 visits per calendar year; and

16. Effective January 1, 2024, Article V, Comprehensive Medical Benefits, section 5.05, "Carpenters Center for Health Benefits," subsection (A)(2) is revised to read as follows:

> (2) Retirees and their eligible Dependents who are not enrolled in either the Comprehensive Medical Benefits or the MAPD Benefit.

17. Effective January 1, 2024, Article VIII, Prescription Drug Benefits, section 8.05, "Medicare Part D Enrollment for the Retiree Plan," is revised to read as follows:

> A Covered Individual who is enrolled in Medicare Part D prescription drug coverage is not eligible for Retiree Plan prescription drug coverage or the MAPD Benefit. If the Participant is not eligible for Retiree Plan prescription drug coverage, then the Participant's Dependents are not eligible for Retiree Plan prescription drug coverage.

18. Effective January 1, 2024, Article XI, Life Insurance Benefits, section 11.03, "Life Insurance Benefit under the Retiree Plan," is amended to read as follows:

> A Retiree who is enrolled in Comprehensive Medical benefits or the MAPD Benefit and dies prior to attaining age sixty-five (65) is eligible for a Life Insurance Benefit as determined by the Trustees from time to time and as provided in the Schedule of Benefits for the Retiree Plan, see Appendix B. In the event of the death of the Retiree prior to his attaining age sixty-five (65), the Life Insurance Benefit will be payable in a lump sum to the beneficiary designated by the Retiree or to the beneficiary determined pursuant to Plan Section 11.04(C)(3). All insured Life Insurance Benefits shall exclusively be considered for payment pursuant to insurance policy maintained by the Plan. The Plan shall not be responsible for paying insured Life Insurance Benefits in the event it is determined that Benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article XI and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

19. Effective January 1, 2024, Article XIV, Coordination of Benefits, section 14.03, "Coordination of Benefits with Medicare under the Retiree Plan of Benefits" is amended to delete subsections (C) and (D).

20. Effective January 1, 2024, Article XIV, Coordination of Benefits, section 14.05, "Coordination of Benefits with Medicare Replacement Plans for the Retiree Plan of Benefits" is deleted. Corresponding cross-references are revised accordingly.

21. Effective January 1, 2024, Appendix A, Schedule of Benefits for Active Plan of Benefits, is amended and restated in its entirety to read as set forth in the attached Exhibit I.

22. Effective January 1, 2024, Appendix B, Schedule of Benefits for Retiree Plan of Benefits, is amended and restated in its entirety to read as set forth in the attached Exhibit II.

23. Effective January 1, 2024, Appendix C, Schedule of Benefits for the Low Cost Medical Plan of Benefits, is amended and restated in its entirety to read as set forth in the attached Exhibit III.

EXHIBIT I

Appendix A

SCHEDULE OF BENEFITS
FOR THE ACTIVE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Active Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). Except as required by law for Protected Services, R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
	Protected Services and Continuing Care Services are payable at the PPO provider rate	
Deductible per Calendar Year	$300 per Covered Individual $900 per family	$600 per Covered Individual $1,800 per family
Out-of-Pocket Maximum per Calendar Year	$2,300 per Covered Individual $6,900 per family (includes Calendar Year Deductible)	$6,000 per Covered Individual $18,000 per family (Does not include Calendar Year Deductible)
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined. Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App A-2	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Behavioral Health Care**	See page App. A-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation support and counseling o Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider		**Out-of-Network Provider**
• **Chiropractic, Acupuncture and Naprapathic Care** (Combined Benefit)	80% paid by Plan		60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12		
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan		60% paid by Plan
	See Plan Sections 5.04(H)		
• **Contraceptives**, including related office visits, to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply		No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage		
• **Dental Service for a Non-Occupational Injury to Teeth**	80% paid by Plan		60% paid by Plan
	Annual Dental Benefit must be exhausted		
	Absolute Solutions Network	**BCBS PPO Provider**	**Out-of-Network Provider**
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	100% paid by Plan (Calendar Year Deductible does not apply)	80% paid by Plan	60% paid by Plan
	BCBS PPO Provider		**Out-of-Network Provider**
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan		60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan		60% paid by Plan
• **Emergency Services** o Facility	80% paid by Plan		80% paid by Plan
o Physician fees	80% paid by Plan		80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum		
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan		60% paid by Plan
	Maximum of 120 days per convalescent period		
• **Gender Affirming Care**	80% paid by Plan		60% paid by Plan
• **Genetic Testing Benefit**			
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply		60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan		60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500		
o Non-diagnostic genetic testing	No coverage		No coverage

	BCBS PPO Provider	Out-of-Network Provider	
• **Hearing Benefit**			
○ Hearing evaluation/exam for a newborn (ages 0 to 31 days) as required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	80% paid by Plan Calendar Year Deductible does not apply	
○ Hearing evaluation/exam	Paid at 100% per Covered Individual once every two (2) consecutive Calendar Years. Calendar Year Deductible does not apply	No coverage	
○ Hearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $5,000 maximum per Covered Individual once every three (3) consecutive Calendar Years Calendar Year Deductible does not apply		
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years Calendar Year Deductible does not apply		
	BCBS PPO Provider	**Out-of-Network Provider**	
• **Home Health Care**	80% paid by Plan	60% paid by Plan	
	Maximum of 120 visits per year		
• **Hospice Care**	80% paid by Plan	60% paid by Plan	
	Lifetime maximum of 180 days per Covered !ndividual		
• **Hospital Care**	80% paid by Plan	60% paid by Plan	
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days		
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing which may be covered above	80% paid by Plan	60% paid by Plan	
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse. No coverage for dependent children.		
• **Infusion Therapy** for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan	
• **Member Assistance Program**	See page App. A-5		
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App A-2		
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage	
• **Oral and Maxillofacial Surgery**	80% paid by Plan	60% paid by Plan	
• **Organ Transplant**	80% paid by Plan	60% paid by Plan	
• **Physician Services**	80% paid by Plan	60% paid by Plan	
• **Pregnancy Care**	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan	
• **Prosthetics** ○ Artificial limbs and eyes	80% paid by Plan	60% paid by Plan	
○ Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum. Calendar Year Deductible does not apply		
• **Reconstructive Breast Surgery**	80% paid by Plan	60% paid by Plan	

	BCBS PPO Provider	Out-of-Network Provider
• **Sterilization** ○ Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
○ Males	80% paid by Plan	No coverage
○ Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See page App. A-5	
• **Surgi-Center Facility** ○ Hospital affiliated	80% paid by Plan	60% paid by Plan
○ No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) ○ Physician and therapy services	80% paid by Plan	60% paid by Plan
○ Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
Therapy Services • **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• Premium Lens replacements in conjunction with cataract surgery	$1,000 maximum per lens (maximum two lenses per lifetime)	$1,000 maximum per lens (maximum two lenses per lifetime)
• **Wellness and Preventive Care** ○ **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see **www.healthcare.gov** for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage

HEALTH CENTER BENEFITS For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions Calendar Year Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)[1]		
	BCBSIL In-Network Provider	**Out-of-Network Provider**
• **Emergency Services** ○ Facility	80% paid by Plan	80% paid by Plan
○ Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room Visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days	
• **Hospital Outpatient Diagnostic Tests**	80% paid by Plan	60% paid by Plan
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

[1] Lyra Health providers may also qualify as Network Providers to the extent they provide services under the Plan's Health Plan Integration Program

VISION CARE BENEFITS

Contracted Network Provider: Vision Service Plan of Illinois (VSP)

Vision coverage is provided by the contracted provider and is described in the insurance policy issued by the contracted provider.

Vision coverage includes, but is not limited to:

	VSP In-Network Provider (Participant's Cost)	**Out-of-Network Provider (Maximum Amount Plan Pays)**
Frequency • **Exam** • **Lenses or contacts** • **Frame**	Once per Calendar Year	
Exam Co-payment	$0 Co-pay	Up to $45
Frame Allowance • Frames up to $200 ($220 for VSP featured frame brands)	$0 Co-pay* *20% savings on amounts above allowance	Up to $70
Lenses • Single vision • Bifocal lined • Trifocal lined • Standard progressive lens • Premium progressive lens • Custom progressive lens	 $0 Co-pay $0 Co-pay $0 Co-pay $0 Co-pay $95-$105 Co-Pay 150-$175 Co-pay	 Up to $30 Up to $50 Up to $65 Up to $50 Up to $50 Up to $50
	VSP In-Network Provider (Participant's Cost)	**Out-of-Network Provider (Maximum Amount Plan Pays)**
Contacts (in lieu of Glasses) • $150 allowance for contacts • Contact lens exam (fitting and evaluation)	$0 Co-pay $40	Up to $105
Safety Glasses (Employees Only) • **Safety Frame** from the ProTec Eyewear Collection • **Lenses –** Prescription single vision, lined bifocal and lined trifocal. Polycarbonate and Progressives covered in full	$10 Co-Pay for frame and lenses	No coverage

DENTAL BENEFITS

Contracted Network Provider: Delta Dental of Illinois

Dental benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Annual Maximum	$2,500		
Annual Deductible (applies only to Basic and Major Care)	$50/person / $100/family		
Balance Billing (the difference between the dentist's actual charge and the amount allowed by Delta Dental.)	Does not apply	Does not apply	Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance
• **Preventive/Diagnostic Care (1)**			
○ Covered Individual through age 18	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum
○ Covered Individual - age 19 and older	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum
• **Basic Care (2)** (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Major Care (3)** (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Orthodontia (4)**	Effective January 1, 2020, when services are rendered by a Delta Dental provider, the orthodontia charges are paid at 80% subject to a lifetime maximum of $5,000.		Paid at 80% of the Dentist's usual fee subject to a lifetime maximum of $2,000

(1) Preventive/Diagnostic Care includes:

- ✓ Oral evaluations (two in 12 month period)
- ✓ Prophylaxis/Cleaning (two in a 12 month period)
- ✓ X-rays (bitewings two in a 12 month period; full mouth or panoramic once in 36 month period; cephalometric once in a 24 month period)
- ✓ Fluoride Treatment (once in a 12 month period for Dependent children through age 18)
- ✓ Palliative Treatment
- ✓ Sealants (once per lifetime on 1st and 2nd molars only, for Dependent children through age 14)

(2) Basic Care includes:

- ✓ Fillings
- ✓ Oral Surgery
- ✓ General Anesthesia
- ✓ Periodontics
- ✓ Endodontics
- ✓ Consultations
- ✓ Removal of cysts & tumors in the mouth
- ✓ Space Maintainers (5-year interval for Dependent children up to age 13)

(3) Major Care includes (services are covered once in a 5 year period) include:

- ✓ Crowns, Jackets & Case Restoration
- ✓ Veneers (Permanent Teeth Only)

✓ Fixed & Removable Bridges ✓ Partial & Full Dentures	✓ Implants and related services

Note: All Frequency limitations listed above are to the day.

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and

Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Omnipod insulin pump	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Select Specialty Medications	Does not apply		See Plan Sections 8.01(D) and 8.02.

SHORT TERM DISABILITY BENEFITS

(For Employees Only)

Non-Occupational (Not work-related)	Weekly benefits include a payment up to $550 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational (Work-related)	Weekly benefits include credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.

LIFE INSURANCE BENEFITS

Contracted Provider: ULLICO

	Eligible Participant	**Spouse**	**Child**
Policy amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS FOR ELIGIBLE EMPLOYEES ONLY Contracted Provider: ULLICO				
Type of Loss	**Benefit Amount**		**Type of Loss**	**Benefit Amount**
Life	$50,000		Both feet	$50,000
One hand and one foot	$50,000		Both hands	$50,000
One foot and sight of one eye	$50,000		Sight of one eye	$25,000
One hand and sight of one eye	$50,000		One foot	$25,000
Sight of both eyes	$50,000		One hand	$25,000
Speech and hearing in both ears	$50,000		Thumb and index finger	$12,500

EXHIBIT II

Appendix B

SCHEDULE OF BENEFITS
FOR THE RETIREE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Retiree Plan of Benefits for Covered Individuals who are not eligible for or enrolled in the MAPD Benefit. The schedule of benefits for Covered Individuals who are enrolled in the MAPD Benefit follows on page App B-7.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C allowance). Except as required by law for Protected Services, R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS FOR COVERED INDIVIDUALS

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
	Protected Services and Continuing Care Services are payable at the PPO provider rate.	
Deductible per Calendar Year	$300 per Covered Individual $600 per family	$600 per Covered Individual
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family (includes deductible)	$6,000 per Covered Individual
	After a Covered Individual satisfies the deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO deductibles and Out-of-Pocket Maximums are separate and cannot be combined. Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.	

BENEFITS FOR COVERED INDIVIDUALS ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit), see page App B-2*	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Behavioral Health Care**	See page App. B-5	
• **Breast Feeding Support and Equipment** as required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children younger than age 12	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
• **Contraceptives,** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	80% paid by Plan	60% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Services** o Facility o Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Gender Affirming Care**	80% paid by Plan	60% paid by Plan
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

	BCBS PPO Provider	Out-of-Network Provider	
• **Hearing Benefit** o Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
oHearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply		
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply		
	BCBS PPO Provider	**Out-of-Network Provider**	
• **Home Health Care**	80% paid by Plan	60% paid by Plan	
	Maximum of 120 days per convalescent period		
• **Hospice Care**	80% paid by Plan	60% paid by Plan	
	Lifetime maximum of 180 days per individual		
• **Hospital Care**	80% paid by Plan	60% paid by Plan	
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.		
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing, which may be covered above	80% paid by Plan	60% paid by Plan	
	Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse. No coverage for dependent children.		
• **Infusion Therapy** for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App B-2		
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No Coverage	
• **Oral and Maxillofacial Surgery**	80% paid by Plan	60% paid by Plan	
• **Organ Transplant**	80% paid by Plan	60% paid by Plan	
• **Physician Services**	80% paid by Plan	60% paid by Plan	
• **Pregnancy Care**	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan	
• **Prosthetics** o Artificial limbs and eyes	80% paid by Plan	60% paid by Plan	
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum Calendar Year Deductible does not apply		
• **Reconstructive Breast Surgery**	80% paid by Plan	60% paid by Plan	

	BCBS In-Network Provider	Out-of-Network Provider
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan; Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See Page App. B-5	
• **Surgi-Center Facility** o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services** o **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
o **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage

HEALTH CENTER BENEFITS	
• **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS FOR COVERED INDIVIDUALS THAT ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS In-Network Provider	**Out-of-Network Provider**
• **Emergency Services** o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours. Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement Maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

PRESCRIPTION BENEFIT

Contracted Network Provider: Express Scripts, Inc. (ESI) and Accredo Specialty Pharmacy

Not available to Deferred Lathers.

	ESI Network Retail Pharmacy (Lesser of 100 pills or a 30 day supply)	**ESI by Mail** (Up to a 90-day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Omnipod insulin pump	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Single-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Non-Select Specialty Medication Out-of-Pocket Maximum per Calendar Year	Does not apply		$1,500 per individual / $3,000 per family
Select Specialty Medications (Co-payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.04.

INSURED BENEFITS	**CARRIER**
• Dental Benefits	Delta Dental of Illinois
• Vision Benefits	Vision Service Plan of Illinois (VSP)
• Life Insurance Benefit ($25,000, Retirees Under Age 65 Only)	ULLICO

SCHEDULE OF BENEFITS
FOR COVERED INDIVIDUALS ENROLLED IN THE MAPD BENEFIT

The schedule on the following highlights key features of the Retiree Plan of Benefits for Covered Individuals who are enrolled in the MAPD Benefit.

- The MAPD Benefits and vision benefits are fully insured and shall exclusively be considered for payment pursuant to the insurance policy maintained by the Plan with the Insurance Company. The Plan shall not be responsible for paying insured benefits in the event the Insurance Company determines that benefits are not payable under the insurance policy. If there is a discrepancy between the benefits described in this Schedule of Benefits, or Plan generally, and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

INSURED BENEFITS	CARRIER
• Medical and prescription drugs	BCBSIL
• Dental Benefits	BCBSIL (network: Dental Network of America)
• Vision Benefits	Vision Service Plan of Illinois (VSP)

HEALTH CENTER BENEFITS	
• **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

EXHIBIT III

Appendix C

SCHEDULE OF BENEFITS
FOR THE LOW COST MEDICAL PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Low Cost Medical Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). Except as required by law for Protected Services, R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	70% paid by Plan	50% paid by Plan
	Protected Services and Continuing Care Services are payable at the PPO provider rate.	
Deductible per Calendar Year	$600 per Covered Individual / $1,800 per family	
Out-of-Pocket Maximum per Calendar Year	$4,600 per Covered Individual / $9,200 per family (includes Deductible)	
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible covered services for the remainder of the Calendar Year. Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care, page App C-2*	
• **Ambulance Service**	70% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	70% paid by Plan	50% paid by Plan
• **Behavioral Health Care**	See page App. C-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	70% paid by Plan	50% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year. No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	70% paid by Plan	50% paid by Plan
	See Plan Section 5.04(H)	
• **Contraceptives** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	70% paid by Plan	50% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	70% paid by Plan	50% paid by Plan
• **Durable Medical Equipment**	70% paid by Plan	50% paid by Plan
• **Emergency Services**	70% paid by Plan	70% paid by Plan
o Facility fees o Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	70% paid by Plan	50% paid by Plan
	Maximum of 120 days per convalescent period	
• **Gender Affirming Care**	70% paid by Plan	50% paid by Plan
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	50% paid by Plan Subject to Calendar Year Deductible, Subject to Out-of-Pocket Maximums and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	70% paid by Plan	50% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage
• **Hearing Benefit**	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
• **Home Health Care**	70% paid by Plan	50% paid by Plan
	Maximum of 120 visits per year	

	BCBS PPO Provider	Out-of-Network Provider
• **Hospice Care**	70% paid by Plan	50% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
• **Hospital Care**	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing which may be covered above	70% paid by Plan	50% paid by Plan
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	70% paid by Plan	50% paid by Plan
• **Member Assistance Program**	See page App. C-5	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App C-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
• **Oral and Maxillofacial Surgery**	70% paid by Plan	50% paid by Plan
• **Organ Transplant**	70% paid by Plan	50% paid by Plan
• **Physician Services**	70% paid by Plan	50% paid by Plan
• **Pregnancy Care**	70% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Deductible does not apply.	50% paid by Plan
• **Prosthetics** ○ Artificial limbs and eyes	70% paid by Plan	50% paid by Plan
○ Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	No coverage	
• **Reconstructive Breast Surgery**	70% paid by Plan	50% paid by Plan
• **Sterilization** ○ Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No Coverage
○ Males	70% paid by Plan	No Coverage
○ Sterilization reversals (female/male)	No Coverage	No Coverage
• **Substance Use Disorder**	See page App. C-5	
• **Surgi-Center Facility** ○ Hospital Affiliated	70% paid by Plan	50% paid by Plan
○ No Hospital Affiliation	70% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	70% paid by Plan	50% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	70% paid by Plan	50% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Temporomandibular Joint Care** (TMJ) ○ Physician and therapy services	70% paid by Plan	50% paid by Plan
○ Appliances, and their adjustments, for TMJ and bruxism (occlusal)	70% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services** ○ **Physical and Speech Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
○ **Occupational Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
○ **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	70% paid by Plan	50% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	70% paid by Plan	50% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	70% paid by Plan	50% paid by Plan
• **Wellness and Preventive Care** ○ **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage

HEALTH CENTER For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra Health In-Network Provider	**Out of Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for twelve sessions per Calendar Year. Calendar Year Deductible does not apply.	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS In-Network Provider[2]	**Out of Network Provider**
• **Emergency Services** ○ Facility	70% paid by Plan	70% paid by Plan
○ Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	70% paid by Plan	50% Paid by Plan
	Confinement maximum: 180 days per calendar year combined for Hospital and Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days.	
• **Hospital Outpatient Diagnostic Tests**	70% paid by Plan	50% paid by Plan
• **Outpatient Therapy** (Including Partial Hospitalization)	70% paid by Plan	50% paid by Plan
• **Custodial or Group Homes**	No coverage	

PRESCRIPTION BENEFITS Contracted Network Provider: Express Scripts, Inc. and Accredo Specialty Pharmacy Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.			
	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	70% paid by Plan		Does not apply
Single-Source Brand Co-payment (A generic is not available)	70% paid by Plan		Does not apply
Multi-Source Brand Co-payment (A generic is available)	70% paid by Plan		Does not apply
Omnipod insulin pump	70% paid by Plan		Does not apply
Non-Select Specialty Medication Co-payment (Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		70% paid by Plan
Select Specialty Medications (Co-Payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.03.

[2] Lyra Health providers may also qualify as Network Providers to the extent they provide services under the Plan's Health Plan Integration Program.

LIFE INSURANCE BENEFITS Contracted Provider: Self-Funded			
	Eligible Participant	**Spouse**	**Child**
Policy amount	$5,000	$1,000	$1,000

EXCLUDED BENEFITS	
Vision Benefits	No coverage
Dental Benefits	No coverage
Short Term Disability Benefits	No coverage
Accidental Death and Dismemberment Insurance Benefits	No coverage

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its February 21, 2024 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees previously took action to amend the Plan to allow coverage for gastric bypass procedures for the diagnosis of bile reflux with bile gastritis; and

WHEREAS, the Trustees previously took action to amend the Plan to self-fund waiver of premium participants from Hartford.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 10, attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — Date: 2/21/23

Gerald W. Thiel, Jr., Secretary — Date: 3/4/24

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AMENDMENT NO. 10
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective June 1, 2023, Article V, Comprehensive Medical Benefits, Section 5.04, "Covered Services and Exclusions," is amended to add a new subsection (RR) to read as follows:

(RR) Gastric Bypass Procedures:

The Plan covers gastric bypass procedures for the diagnosis of bile reflux with bile gastritis.

2. Effective July 1, 2023, the second paragraph of Article XI, Life Insurance Benefits, Section 11.01, "Life Insurance Benefits for an Eligible Employee under the Active and Low-Cost Medical Plans," is amended as follows:

Except for certain extensions of benefits, Life Insurance Benefits for Covered Individuals under the Active Plan of Benefits shall exclusively be considered for payment pursuant to insurance policies maintained by the Plan. The Plan shall not be responsible for paying insured Life Insurance Benefits in the event it is determined that Benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article XI and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

3. Effective July 1, 2023, Article XI, Life Insurance Benefits, Section 11.07, "Extension of Life Insurance Benefits for an Employee Who Becomes Totally and Permanently Disabled Under the Active Plan," is amended to read as follows:

If an Employee who is eligible for benefits under the Active Plan of Benefits becomes totally and permanently Disabled while eligible for Life Insurance Benefits, but before the Employee reaches age sixty (60), the Fund will continue the Employee's Life Insurance Benefit by paying the Insurance Company the required premium as long as the Employee remains totally and permanently disabled. For certain Employees who the Fund determines are totally and permanently disabled and who, due to a change in Life Insurance Companies, are no longer covered under either Insurance Company group policy, the Fund may self-fund the benefit.

The following conditions apply to the extension of Life Insurance Benefit:

A. An Employee must be considered totally and permanently Disabled as determined by the Insurance Company. For self-funded extension of benefits, an Employee is considered totally and permanently Disabled if:

(1) The Illness or Injury prevents the Employee from working at his job or any other job for pay or profit; and

(2) The Employee has been totally Disabled for at least nine (9) months.

B. The totally and permanently Disabled Employee must request and file an application for an extension of Life Insurance Benefits with the Fund Office within twelve (12) months after the loss of eligibility.

C. Proof of total and permanent Disability and subsequent proof must be submitted to the Insurance Company or Fund Office upon request. If the Insurance Company or Fund Office determines that the Employee is no longer totally and permanently Disabled, or if the Employee has recovered from his disability and is able to work, the Employee's Life Insurance will terminate.

D. In the event the group policy is discontinued, the Employee's Life Insurance will terminate.

E. Applying for or qualifying for a Disability Benefit under a Pension Fund does not constitute application for this Life Insurance Benefit extension. The totally and permanently disabled Employee must file a separate application with the Health Fund.

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its May 22, 2024 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS the Trustees desire to amend the Plan to clarify the rules related to the insured MAPD benefit.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 11, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — 5/22/24 Date

Gerald W. Thiel, Jr., Secretary — 5/22/24 Date

AMENDMENT NO. 11
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective January 1, 2024, Article II, Definitions, is amended to add a new section 2.10 to read as follows, and all subsequent sections and cross-references are renumbered accordingly:

Section 2.10 CMS

"CMS" means the Centers for Medicare & Medicaid Services.

2. Effective January 1, 2024, Article III, Eligibility, section 3.03, "Eligibility for Retirees and Certain Eligible Dependents," subsection (C) is restated in its entirety to read as follows:

(C) Surviving Dependents will be eligible for the Retiree Plan of Benefits as follows:

(1) For Retirees enrolled in the Retiree Plan of Benefits who die on or after December 1, 2018, a Dependent spouse who was enrolled or eligible to enroll under the Retiree Plan of Benefits immediately prior to the Retiree's death and any of the deceased Retiree's Dependents who were enrolled or eligible to enroll under the Retiree Plan of Benefits at the time of the Retiree's death, shall be eligible to continue participating in the Retiree Plan of Benefits, provided such surviving spouse (and any surviving Dependents) waive their rights to Continuation of Coverage under COBRA with respect to the Participant's death and notify the Fund Office of the Retiree's death within ninety (90) days of the date of death.

(2) A Dependent spouse or any other Dependent who was enrolled in the MAPD Benefit at the time of the Retiree's death shall remain eligible for and enrolled in the MAPD Benefit provided the Fund Office is notified of the Retiree's death within ninety (90) days of the date of death.

(3) A Dependent spouse of an Employee eligible for benefits in the Active Plan or the Low Cost Medical Plan at the time of his death shall be eligible to enroll in the Retiree Plan of Benefits, provided the following conditions are satisfied:

(a) The Employee dies on or after July 1, 2019 and at the time of his death was eligible for health benefits

under the Active Plan, or the Low Cost Medical Plan, and was age sixty (60) or older;

(b) The Dependent spouse was married to the Employee for at least one (1) year preceding the Employee's death;

(c) The Employee would have qualified for coverage under the Retiree Plan at the time of his death;

(d) The surviving spouse is eligible for a Joint & Survivor Pension benefit under a Pension Fund; and

(e) The Fund Office is notified of the Employee's death within ninety (90) days of the date of death.

If the above conditions are satisfied, then in addition to the surviving spouse, any other Dependents enrolled in the Active Plan or the Low Cost Medical Plan, at the time of the Employee's death shall be eligible to enroll in the Retiree Plan of Benefits. In order to enroll in the Retiree Plan of Benefits, the surviving spouse (and any surviving Dependents) must waive their rights to Continuation of Coverage under COBRA with respect to the Participant's death.

3. Effective January 1, 2024, Article III, Eligibility, section 3.04, "Eligibility for Different Types of Retiree Coverage," subsection (A) is amended to read as follows:

(A) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A), Paragraphs 1 thru 5, and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are not Medicare eligible are eligible to enroll in the following coverage options::

(1) The prescription drug benefit, as described in Article VIII and Appendix B, except Deferred Lathers are not eligible for the prescription drug benefit; and comprehensive medical benefits as described in Article V and Appendix B; and/or

(2) Dental benefits as described in Article VII and Appendix B; and/or

(3) Vision benefits as described in Article VI and Appendix B.

Retirees who retired prior to January 1, 2024 can separately elect prescription drug benefit and/or comprehensive medical benefits in addition to dental and/or vision benefits. However, Will County Local 174 Carpenters Welfare Fund retirees who retired on December 1, 2018 or earlier must elect and maintain both the prescription drug and comprehensive medical benefits under this

Plan Section 3.04(A)(1) and (2), but have the option of separately electing dental or vision benefits.

Dependents who are not eligible for Medicare may only enroll in the coverage options that the Retiree is enrolled in. Dependents who are eligible for Medicare may only enroll in the dental and/or vision benefits that the Retiree is enrolled in and/or the MAPD Benefit.

4. Effective January 1, 2024, a new subsection (E) is added to Article III, Eligibility, section 3.04, "Eligibility for Different Types of Retiree Coverage," to read as follows:

(E) Notwithstanding anything to the contradictory above, Retirees, Dependents and surviving dependents will be eligible for the MAPD Benefit only upon meeting the Contracted Provider and/or CMS requirements.

5. Effective January 1, 2024, a new subsection (D) is added to Article III, Eligibility, section 3.05, "Enrollment for Retiree Plan of Benefits," to read as follows:

(D) Enrollment in the MAPD Benefit: Consistent with Contracted Provider and/or CMS requirements, a Retiree or Dependent must submit required enrollment materials to the Contracted Provider within ninety (90) days of the date they are initially eligible for coverage to be effective as of the date of initial eligibility. If the Retiree or Dependent submits the required enrollment materials to the Contracted Provider between day ninety (90) and one hundred and five (105), coverage will be effective the first of the month following receipt of the required enrollment materials or, if requested, retroactive to the date of initial eligibility if the Contracted Provider and/or CMS approves the request. A Retiree or Dependent who fails to submit required enrollment materials within one hundred and five (105) days from the date of initial eligibility will not be eligible to enroll in the MAPD Benefit.

6. Effective January 1, 2024, Article III, Eligibility, section 3.07, "Premium Payments for Retiree Coverage," is amended to revise subsection (A)(1)-(3) as follows:

(1) Each Covered Individual not eligible for the MAPD Benefit must pay:

(a) A monthly premium for comprehensive medical benefits.

(b) A separate monthly premium for the prescription drug benefit except the Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(2) Each Covered Individual eligible for the MAPD Benefit must pay a separate monthly premium for the MAPD Benefit. If retroactive coverage is requested and approved by the Contracted Provider

and/or CMS, the Covered Individual must pay the monthly premium for those retroactive months.

(3) Each Covered Individual not eligible for or enrolled in the MAPD Benefit must pay a separate monthly premium for dental benefits. The monthly premium rates for dental benefits are determined by the Insurance Company.

7. Effective January 1, 2024, Article III, Eligibility, section 3.07, "Premium Payments for Retiree Coverage," is amended to revise subsection (B) in its entirety to read as follows:

(B) Premiums for Retirees and their Dependents or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) where the Retiree has a pension annuity starting date of June 1, 2006 or earlier will be determined based on the following:

(1) Covered Individuals eligible for the MAPD Benefit must pay a separate monthly premium for the MAPD Benefit. If retroactive coverage is requested and approved by the Contracted Provider and/or CMS, the Covered Individual must pay the monthly premium for those retroactive months.

(2) Covered Individuals not eligible for the MAPD Benefit but who are eligible for prescription drug benefits must pay a monthly premium for the prescription drug benefit except Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(3) Each Covered Individual not eligible for or enrolled in the MAPD Benefit must pay a separate monthly premium for dental benefits. The monthly premium rates for dental benefits are determined by the Insurance Company.

(4) Each Covered Individual must pay a separate monthly premium for vision benefits. The monthly premium rates for vision benefits are determined by the Insurance Company.

(5) Premiums for surviving spouses (and any surviving Dependents) added by the Retiree after June 1, 2006 will be subject to the tiered premiums as described in Plan Section 3.07(A).

8. Effective January 1, 2024, Article III, Eligibility, section 3.13, "Termination of Eligibility under the Retiree Plan," is amended to add a new subsection (A)(7) to read as follows:

(7) The date the Contracted Provider terminates the Retiree's coverage under the MAPD Benefit.

9. Effective January 1, 2024, Article III, Eligibility, section 3.13, "Termination of Eligibility under the Retiree Plan," is amended to add a new subsection (B)(7) to read as follows:

(7) The date the Contracted Provider terminates the surviving spouse or Dependent's coverage under the MAPD Benefit.

10. Effective January 1, 2024, Article III, Eligibility, section 3.13, "Termination of Eligibility under the Retiree Plan," subsection (D) is amended to read as follows:

(D) To voluntarily cancel Retiree benefit coverage a Retiree or surviving spouse (and any surviving Dependents) who is eligible pursuant to Plan Section 3.03(C) and enrolled pursuant to Plan Section 3.05(B), must obtain the required forms from the Fund Office and return the completed forms to the Fund Office by the fifteenth (15th) day of the month prior to the month that coverage will be cancelled. A Retiree or surviving spouse covered under the MAPD Benefit may voluntarily cancel MAPD Benefit coverage in accordance with the procedures established by the Contracted Provider and/or CMS.

If coverage is cancelled for the Retiree or surviving spouse, it will also be cancelled for the enrolled Dependents. Once coverage under the Retiree Plan is cancelled for a Retiree, Dependent, or surviving spouse (and any surviving Dependents), coverage under the Retiree Plan cannot be reinstated for the Retiree, Dependent or surviving spouse (and any surviving Dependents) at a later date for any reason, even following subsequent re-employment, except as provided in Plan Section 3.05. If Retiree Plan coverage is voluntarily cancelled for a Retiree's surviving spouse or Dependent (including surviving Dependents) due to the surviving spouse or Dependent obtaining coverage through an Outside Plan or Medicaid, re-enrollment in the Retiree Plan is only allowed until the first (1st) day of the month after the Outside Plan or Medicaid coverage terminates for the Dependent. Re-enrollment for the surviving spouse or Dependent (including surviving Dependents) is allowed only for the benefit(s) that are provided under the Outside Plan or Medicaid. The Retiree must re-enroll the Retiree's Dependent in the Retiree Plan no later than the first (1st) day of the month following the termination of the Outside Plan or Medicaid coverage; this deadline also applies to surviving spouses (and any surviving Dependents).

11. Effective January 1, 2024, Article III, Eligibility, section 3.17, "Termination of Dependent Eligibility," subsection (M) is amended to read as follows:

(M) The coverage of a Dependent of a Retiree enrolled in the Retiree Plan of Benefits terminates on the last day of the month in which the Retiree dies, except as provided in Plan Section 3.03(C) and 3.05(B) and except that coverage of a Dependent spouse or other Dependent enrolled in the MAPD Benefit will not terminate upon the Retiree's death;

12. Effective January 1, 2024, Article VIII, Prescription Drug Benefits, section 8.05, "Medicare Part D Enrollment for the Retiree Plan," is revised to read as follows:

> A Covered Individual who is enrolled in Medicare Part D prescription drug coverage through an Outside Plan is not eligible for Retiree Plan prescription drug coverage or the MAPD Benefit. If the Participant is not eligible for Retiree Plan prescription drug coverage, then the Participant's Dependents are not eligible for Retiree Plan prescription drug coverage.

13. Effective May 22, 2024, Article III, Eligibility, section 3.03, "Eligibility for Retirees and Certain Eligible Dependents," is amended to revise subsection (A)(2) as follows:

> (2) Commenced receiving pension benefits from the Carpenters Pension Fund of Illinois as a member of Local Union Nos. 363, 916 or 2087 or as a former full-time employee of Illinois Employee Benefits Corp. on or after March 1, 2003 based on at least ten (10) years of Eligibility Service. If at some time the Participant did not earn Eligibility Service for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of Eligibility Service;

14. Effective May 22, 2024, Article III, Eligibility, section 3.07, "Premium Payments for Retiree Coverage," is amended to revise subsection (D) as follows:

> (D) Premiums for coverage are paid through deductions from the Retiree's or, if a surviving spouse pension benefit is payable, the surviving spouse's monthly pension benefit pursuant to payment assignments executed by the Retiree or the surviving spouse who satisfies the eligibility criteria in Plan Section 3.03(C). If the premium for coverage is greater than the gross monthly pension benefit, the Retiree or the surviving spouse must submit a Premium Payment directly to the Fund. Premium Payments must be received by the Fund no later than the first business day of the month for which coverage is effective. However there is a grace period as described in Plan Section 4.01(E)(3)(c) in the same manner as for Continuation Coverage under COBRA. The Fund also allows the Retiree, surviving spouse, or surviving Dependent to pre-pay up to twelve (12) months of Premium Payments. Upon the death of the Retiree, surviving spouse, or surviving Dependent any remaining prepaid Premium Payments will be refunded to the Retiree's, surviving spouse's, or surviving Dependent's estate.
>
> The obligation to pay a Premium Payment for coverage from the Retiree's monthly pension benefit pursuant to a payment assignment executed by the Retiree will not apply to the extent that the Plan is required to accept a third-party Premium Payment on behalf of the Retiree pursuant to a Qualified Medical Child Support Order.

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its August 28, 2024 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees took action at their May 22, 2024 Board of Trustees' meeting to amend the Plan to amend the Plan to:

- Cover nutritional counseling for obesity and prediabetes; and
- Exclude gene therapy coverage.

WHEREAS, the Trustees desire to amend the Plan to:

- Allow Trustees to enter into Participation Agreements that establish monthly eligibility requirements;
- Allow employees of the MACRC Benefit Funds, LLC to receive short-term disability benefits following 6 months of employment;
- Require updated address or bank deposit routing information for distribution of vacation benefits;
- Provide that an employee retiring under a Specialty Shop agreement is eligible for Retiree coverage following 10 years of continuous coverage under the Plan; and
- Allow surviving dependents of a disabled participant to continue coverage under the Retiree plan.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 12, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — AUG 28, 2024 — Date

Gerald W. Thiel, Jr., Secretary — 8/28/2024 — Date

AMENDMENT NO. 12
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective August 1, 2023, Article V, Comprehensive Medical Benefits, section 5.04(Z)(c) is amended to read as follows:

> (c) For treatment of eating and gastrointestinal disorders; cardiovascular, kidney, chronic obstructive pulmonary diseases; obesity; prediabetes; diabetes; hypertension; seizures; and cancer.

2. Effective June 1, 2024, Article II, Definitions, is amended to add a new section 2.50 to read as follows:

> **Section 2.50 Gene-Based Cell Therapy**
>
> "Gene-Based Cell Therapy" involves removing cells from a patient, altering them using gene therapy, and then implanting the modified cells back into the patient's body.

All subsequent sections and cross-references are revised accordingly.

3. Effective June 1, 2024, Article II, Definitions, is amended to add a new section 2.51 to read as follows:

> **Section 2.51 Gene Therapy**
>
> "Gene Therapy" means a therapy that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms: replacing a disease-causing gene with a healthy copy of the gene, inactivating a disease-causing gene that is not functioning properly, or introducing a new or modified gene into the body to help tread a disease, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational.

All subsequent sections and cross-references are revised accordingly.

4. Effective June 1, 2024, Article III, Eligibility, section 3.01(B) is amended to read as follows:

> (B) The Trustees may either enter into Participation Agreements or accept Collective Bargaining Agreements with Employers that permit the Employer to contribute advance payments to the Fund that accelerate participation of the Employees who had worked in a non-contributing or contributory category of employment and/or that establish monthly eligibility requirements.

5. Effective June 1, 2024, Article III, Eligibility, section 3.09(D) is amended to read as follows:

(D) For Employees who are covered under a Participation Agreements or a Collective Bargaining Agreement with Employers, as stated in Article 3.01(B), after the Employee is initially eligible, the Fund Office must continue to receive a monthly Contribution based on the minimum hour requirement stated in their Participation Agreement or Collective Bargaining Agreement for the Employee's coverage to continue for that month.

6. Effective June 1, 2024, Article VIII, Prescription Drug Benefits, section 8.06, is amended to add new subsection (S) to read as follows:

(S) Expenses for or related to Gene Therapy and/or Gene-Based Cell Therapy.

7. Effective June 1, 2024, Article XIII, Exclusions and Limitations, section 13.01 is amended to add new subsection (S) to read as follow:

(S) Expenses for or related to Gene Therapy and/or Gene-Based Cell Therapy.

8. Effective June 1, 2024, Article X, Short Term Disability Benefits, sections 10.01(A) and (B) are amended in their entirety to read as follows:

(A) Non-Occupational Illness or Injury: The following conditions apply:

(1) Eligibility: An Employee must suffer a Non-Occupational Illness or Injury resulting in Disability that began in a Coverage Quarter in which the Employee is eligible for benefits and is not a Retiree. Eligibility for Employees who are subject to a Participation Agreement and who do not work in a bargaining unit represented by the Union is set forth in Plan Section 10.05.

(2) Maximum Period: The Employee will receive a weekly payment and will be credited with a maximum of forty (40) Contribution hours to this Plan for each calendar week of Physician certified or proven Disability up to a maximum of fifty-two (52) weeks (two thousand and eighty (2,080) hours) during the period of time the Employee remains Disabled for any single period of Disability for the same or related Non-Occupational Illness or Injury.

(3) Weekly payments and credit of Contribution hours for a Non-Occupational Injury or Accident begin from the first full day of the proven Disability regardless of the length of the disability.

(4) Weekly payments and credit of Contribution hours for a Non-Occupational Illness begin from the eighth (8th) calendar day after the Employee first becomes Disabled, except if the Employee is continuously Disabled for four (4) weeks or longer, benefits are payable beginning as of the first full day of a Disability.

(5) Continuous Disability: Disabilities occurring in any twelve (12) month period of time are considered as one and the same Claim if the Disability is for the same or related Non-Occupational Illness or Injury.

(B) Occupational Illness or Injury: The following conditions apply:

(1) Eligibility: An Employee must suffer an Occupational Illness or Injury resulting in Disability which began in a Coverage Quarter in which the Employee is eligible for benefits, and is not a Retiree. Eligibility for Employees who are subject to a Participation Agreement and who do not work in a bargaining unit represented by the Union is set forth in Plan Section 10.05.

(2) Maximum Period: The Employee will be credited with a maximum of forty (40) Contribution hours to this Plan for each week of proven Disability up to a maximum of fifty-two (52) weeks (two thousand and eighty (2,080) hours) during the period of time the Employee remains Disabled for any single period of continuous Disability for the same or related Occupational Illness or Injury.

(3) Credit of Contribution hours for an Occupational Disability begins from the first full day of the Physician certified or proven Disability regardless of the length of the disability.

(4) Continuous Disability: Disabilities occurring in any twelve (12) month period of time are considered as one and the same Claim if the Disability is for the same or related Occupational Illness or Injury.

(5) A weekly benefit payment is not available for an Occupational Illness or Injury.

(6) The Plan will not pay Covered Medical Expenses for an Occupational Illness or Injury.

(7) Short Term Disability Benefits are not available for Employees whose Occupational Illness or Injury occurred while employed by a non-Employer.

9. Effective June 1, 2024, Article X, Short Term Disability Benefits, section 10.05 is amended in its entirety to read as follows:

Section 10.05 Employees Subject to a Participation Agreement and Who Do Not Work in a Bargaining Unit Represented by the Union

In addition to satisfying the conditions imposed under Plan Section 10.01(A) and (B), Employees who are subject to a Participation Agreement and who do not work in a bargaining unit represented by the Union must be actively employed by

their Employer on the date they suffer a Disability to qualify for Short Term Disability Benefits. Employees of the MACRC Benefit Funds, LLC, will become eligible for Short Term Disability Benefits following six (6) consecutive months of employment.

10. Effective August 28, 2024, Article III, Eligibility, section 3.03(C)(1) is amended to read as follows read as follows:

(1) For Retirees who are either enrolled in the Retiree Plan of Benefits or still eligible for coverage under the Active Plan and who die on or after December 1, 2018, a Dependent spouse who was enrolled or eligible to enroll under the Retiree Plan of Benefits immediately prior to the Retiree's death and any of the deceased Retiree's Dependents who were enrolled or eligible to enroll under the Retiree Plan of Benefits at the time of the Retiree's death, shall be eligible to continue participating in the Retiree Plan of Benefits, provided such surviving spouse (and any surviving Dependents) waive their rights to Continuation of Coverage under COBRA with respect to the Participant's death and notify the Fund Office of the Retiree's death within ninety (90) days of the date of death.

11. Effective September 1, 2024, Article XIX, Vacation Benefit, section 19.05 is amended to read as follows:

(A) The Fund has adopted appropriate procedures to regularly review when a check is returned or is unclaimed. If after exhausting these procedures the Fund is unable to locate the Employee or deliver the check, the payment will be temporarily forfeited subject to re-issue if the Employee subsequently pursues payment. Also, if an Employee fails to update his address information or provide valid bank deposit routing instructions, the Fund will forgo distributing benefits to that Employee until the necessary information is provided. The Fund will follow similar procedures, including temporary forfeitures, for checks that are delivered but not negotiated. The Fund may issue a stop pay order where necessary.

12. Effective January 1, 2025, Article III, Eligibility, section 3.03(A) is amended to add a new subsection (7) to read as follows read as follows:

(7) Retires from a Specialty Shop with at least ten (10) years of continuous coverage under the Active Plan or Low Cost Plan. For purposes of this section 3.03(A)(7), a "Specialty Shop" means a business with which the Mid-America Carpenters Regional Council, United Brotherhood of Carpenters and Joiners of America has a specific "industrial," "in-plant" or "in-shop" collective bargaining agreement providing for wage rates and working conditions, but which did not require contributions to the Pension Fund.

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its November 26, 2024 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees previously took action when adopting Amendment No. 12 to amend the Plan to exclude gene therapy coverage effective June 1, 2024. Due to the time required to update administration, the Trustees desire to delay the exclusion effective date to January 1, 2025;

WHEREAS, the Trustees took action at the October 7, 2024 Benefit Study Committee meeting to amend the Plan to increase the hour requirements to maintain eligibility for the Active Plan to 300 hours in the trailing quarter and 1,200 for the 12-month look back period, effective with the coverage quarter beginning June 1, 2025;

WHEREAS, the Trustees also took action at the October 7, 2024 Benefit Study Committee meeting to amend the Plan to increase the hour requirements to for apprentices to maintain eligibility in the Active Plan without prescription drug and dental benefits to 960 hours for the 12-month look back period, effective with the coverage quarter beginning June 1, 2025.

NOW, THEREFORE, BE IT RESOLVED, that Plan will exclude gene therapy in the manner reflected in Amendment No. 12 effective January 1, 2025; and

FURTHER RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 13, as set forth as Exhibit A attached hereto, effective January 1, 2025.

Gary Perinar, Chairman — 11/26/24 Date

Gerald W. Thiel, Jr., Secretary — 11/26/24 Date

AMENDMENT NO. 13
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

Effective January 1, 2025, the Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Article III, "Eligibility", section 3.09, "Continuing Eligibility for Non-Apprentice Employees under the Active Plan," subsections (A) and (B) are amended to read as follows:

(A) After an Employee who is not an apprentice meets the initial eligibility requirements in Plan Section 3.01, the Employee becomes a Participant in the Active Plan for a Coverage Quarter. Effective for coverage quarters beginning on and after June 1, 2025, to maintain coverage in the Active Plan, the Employee must have at least three hundred (300) hours (prior to the June 1, 2025 Coverage Quarter, at least two hundred and fifty (250) hours) during each succeeding Calendar Quarter of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

(B) If an Employee does not meet the requirements of Plan Section 3.09(A), the Employee will remain a Participant in the Active Plan for the next Coverage Quarter if, for Coverage Quarters beginning on and after June 1, 2025, he has at least one thousand, two hundred (1,200) hours (prior to the June 1, 2025 Coverage Quarter, at least one thousand (1,000) hours) in the current and the three (3) immediately preceding Calendar Quarters of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

2. Article III, "Eligibility", section 3.10, "Continuing Eligibility for Apprentices under the Active Plan," subsections (B), (C) and (D) are amended to read as follows:

(B) If the apprentice does not meet the requirements of Plan Section 3.10(A), the apprentice will remain a Participant in the Active Plan (except he will not receive the prescription drug benefit and dental benefit) for the next Coverage Quarter if, for Coverage Quarters beginning on and after June 1, 2025, he has at least nine hundred and sixty (960) hours (prior to the June 1, 2025 Coverage Quarter, at least seven hundred and sixty (760) hours) in the current and the three (3) immediately preceding Calendar Quarters of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

The foregoing to the contrary notwithstanding, an apprentice who is dropped from the Apprentice Program or if he otherwise ceases to be enrolled in the Apprentice Program, and who does not meet the requirements of Plan Section 3.10(A), shall be ineligible to maintain his Active Plan benefit coverage (without prescription drug benefit and dental benefit) under this Plan Section 3.10(B).

(C) Once the initial requirements for eligibility are met, an apprentice may qualify for full Active Plan benefits (including the prescription drug benefit and dental benefit) during subsequent Coverage Quarters if, for Coverage Quarters beginning on and after June 1, 2025, the apprentice has at least three hundred (300) hours (prior to the June 1, 2025 Coverage Quarter, two hundred and fifty (250) hours) during the immediately preceding Calendar Quarter of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

(D) In addition to Plan Section 3.10(C), the apprentice's eligibility for full Active Plan benefit coverage will be maintained for subsequent Coverage Quarters if, for Coverage Quarters beginning on and after June 1, 2025, the apprentice has credit for at least one thousand, two hundred (1,200) hours (prior to the June 1, 2025 Coverage Quarter, one thousand (1,000) hours) in the current and three (3) immediately preceding Calendar Quarters of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

3. Article III, "Eligibility", section 3.11, "Continuing Eligibility for the Active Plan Through Self-Payment of Hours, subsection (B)(2), "Non-Apprentices" is amended to read as follows:

(2) The Self-Payment of Hours Premium is equal to the lesser of:

(a) The difference between the credited hours for the current Calendar Quarter and, for Coverage Quarters beginning on and after June 1, 2025, three hundred (300) hours (prior to the June 1, 2025 Coverage Quarter, two hundred and fifty (250) hours), multiplied by the Current Hourly Contribution Rate; or

(b) The difference between the credited hours for the current Calendar Quarter and the three (3) immediately preceding Calendar Quarters and, for Coverage Quarters beginning on and after June 1, 2025, one thousand, two hundred (1,200) hours (prior to the June 1, 2025 Coverage Quarter, one thousand (1,000) hours), multiplied by the Current Hourly Contribution Rate.

4. Article III, "Eligibility", sections 3.11"Continuing Eligibility for the Active Plan Through Self-Payment of Hours, subsection (C)(2) and (3), "Apprentices" are amended to read as follows:

(2) The Self-Payment of Hours Premium, without prescription drug and dental benefits, is equal to the lesser of:

(a) The difference between the credited hours for the current Calendar Quarter and two hundred (200) hours, multiplied by Current Hourly Contribution Rate; or

(b) The difference between the credited hours for the current Calendar Quarter and the three (3) immediately preceding Calendar Quarters and, for Coverage Quarters beginning on and after June 1, 2025, nine hundred and sixty (960) hours (prior to the June 1, 2025 Coverage Quarter, seven hundred and sixty (760) hours), multiplied by the Current Hourly Contribution Rate.

(3) The Self-Payment of Hours Premium, with prescription drug and dental benefits, is equal to the lesser of:

(a) The difference between the credited hours for the current Calendar Quarter and, for Coverage Quarters beginning on and after June 1, 2025, three hundred (300) hours (prior to the June 1, 2025 Coverage Quarter, two hundred and fifty (250) hours), multiplied by the Current Hourly Contribution Rate; or

(b) The difference between the credited hours for the current Calendar Quarter and the three (3) immediately preceding Calendar Quarters and, for Coverage Quarters beginning on and after June 1, 2025, one thousand, two hundred (1,200) hours (prior to the June 1, 2025 Coverage Quarter, one thousand (1,000) hours), multiplied by the Current Hourly Contribution Rate.

5. Article III, "Eligibility", section 3.14, "Reinstatement of Eligibility for a Participant under the Active Plan," is amended to read as follows:

(A) If a Participant loses eligibility for benefits under the Active Plan because the Employee did not have the required Contribution hours paid for a period of less than twelve (12) consecutive Calendar Quarters (three (3) years), the Employee may again become eligible on the first day of the Coverage Quarter following a Calendar Quarter in which Contributions for at least three hundred (300) hours (for Coverage Quarters beginning on and after June 1, 2025; prior to the June 1, 2025 Coverage Quarter, at least two hundred and fifty (250) hours) were paid on the Employee's behalf by one or more Contributing Employers.

(B) If an Employee returns to work after being away for longer than twelve (12) or more consecutive Calendar Quarters (three (3) years), with no contribution hours paid on the Employee's behalf, the Employee must

again meet the Initial Eligibility requirements as a new Participant as stated under Plan Section 3.01.

(C) If the Employee's absence from Covered Employment was the result of a Disability, the Employee's reinstatement will be effective on the first (1st) day of the Coverage Quarter following a Calendar Quarter in which at least three hundred (300) hours (for Coverage Quarters beginning on and after June 1, 2025; prior to the June 1, 2025 Coverage Quarter, at least two hundred and fifty (250) hours) were credited on the Employee's behalf.

(D) If the Participant's eligibility for benefits is suspended because the Participant goes on a leave as defined under USERRA, eligibility will be immediately reinstated, as it was on the day before termination, upon the Participant's release from service as described in Plan Section 4.03.

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") at its February 26, 2025 meeting:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan to expand mastectomy coverage as required under the Women's Health and Cancer Rights Act.

WHEREAS, the Trustees desire to further amend the Plan to clarify that spouse beneficiary designations are void upon divorce.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to amend the Plan by adopting Amendment No. 14, as set forth as Exhibit A attached hereto, effective as of February 26, 2025.

Gary Perinar, Chairman — Date: 2/26/25

Gerald W. Thiel, Jr., Secretary — Date: 2/26/2025

AMENDMENT NO. 14
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

Effective February 26, 2025, the Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Article V, "Comprehensive Medical Benefits," section 5.04(FF) is amended to read as follows:

(FF) Reconstructive Surgery:

(1) The Plan covers reconstructive surgery as required under the Women's Health and Cancer Rights Act, as follows:

(a) Post mastectomy breast or aesthetic flat closure surgery without regard to the time elapsed since the mastectomy;

(b) Reconstruction of the breast on which the mastectomy was performed;

(c) Surgery and reconstruction of the other breast for the purpose of achieving reasonable breast symmetry; and

(d) Prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas in a manner determined in consultation with the attending provider and the patient.

2. Article XI "Life Insurance Benefits," section 11.04, "Beneficiary Designation for the Life Insurance Benefit," is amended to add a new subsection (D) to read as follows:

(D) In the event of divorce, a beneficiary designation naming the Employee's or Retiree's former spouse as the Beneficiary (but not other Beneficiary designations), will be cancelled as of the date of divorce, unless the Fund receives a qualified domestic relations order naming the former spouse as the Employee's or Retiree's beneficiary for life insurance purposes, or the Employee or Retiree re-designates the former spouse as Beneficiary following the divorce.

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") on May 21, 2025:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan to reflect that the Mid-America Regional Council Millmen Pension Plan merged into the Mid-America Carpenters Regional Council Pension Plan, effective June 30, 2023;

WHEREAS, the Trustees desire to amend the Plan to reflect that County Local 174 Carpenters Pension Fund merged into the Mid-America Carpenters Regional Council Pension Plan, effective December 31, 2024; and

WHEREAS, the Trustees desire to amend the Plan to implement a maternity leave benefit effective July 1, 2025.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to reflect that the Trustees at their May 21, 2025 meeting resolved to amend the Plan by adopting Amendment No. 15, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — 5/21/25 Date

Gerald W. Thiel, Jr., Secretary — 5/21/25 Date

AMENDMENT NO. 15
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

Effective July 1, 2025, the Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Article II, "Definitions," section 2.80, "Pension Fund," is amended to read as follows:

> "Pension Funds" means collectively the Mid-America Carpenters Regional Council Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Fund"), the Mid-America Carpenters Regional Council Millmen Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Fund"), the Carpenters Pension Fund of Illinois, and the Will County Local 174 Carpenters Pension Fund. Effective June 30, 2023, the Mid-America Carpenters Regional Council Millmen Pension Fund merged into the Mid-America Carpenters Regional Council Pension Fund. Similarly, effective December 31, 2024, the Will County Local 174 Carpenters Pension Fund merged into the Mid-America Carpenters Regional Council Pension Fund.

2. Article II, "Definitions," section 2.81, "Pension Plans," is amended to read as follows:

> "Pension Plans" means collectively the Mid-America Carpenters Regional Council Pension Plan (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Plan"), the Mid-America Regional Council Millmen Pension Plan (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Plan"), the Carpenters Pension Fund of Illinois Plan, and the Will County Local 174 Carpenters Pension Plan. Effective June 30, 2023, the Mid-America Carpenters Regional Council Millmen Pension Plan merged into the Mid-America Carpenters Regional Council Pension Plan. Similarly, effective December 31, 2024, the Will County Local 174 Carpenters Pension Plan merged into the Mid-America Carpenters Regional Council Pension Plan.

3. The introduction to Article X, "Short Term Disability Benefits" is amended to read as follows:

> The Plan provides an Employee with Short Term Disability Benefits for a Non-Occupational Illness or Injury (called "Non-Occupational Short Term Disability Benefits" or "Non-Occupational Disability"), an Occupational Illness or Injury (called "Occupational Short Term Disability Benefits" or "Occupational Disability") and maternity leave (called "Maternity Leave Benefits") as specified in this Article X. Benefits are determined by the Trustees from time to time and provided in the Schedule of Benefits for the Active Plan, see Appendix A.

4. Article X, "Short Term Disability Benefits" is amended to add a new section 10.07 entitled "Maternity Leave Benefits" to read as follows:

> Section 10.07 Maternity Leave Benefits

(A) Eligibility: Pregnant Employees are eligible for Maternity Leave Benefits. Non-bargained Employees, Employees covered by the Low-Cost Medical Plan, former Employees on Continuation Coverage, and Retirees are not eligible for Maternity Leave Benefits.

For purposes of this Section 10.07, "Non-bargained Employees" means an employee for whom an Employer is obligated to contribute to the Health Fund pursuant to a Participation Agreement or other written agreement.

(B) Maximum Period: The Employee 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. Contribution hours do not include HRA contributions.

(C) 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 Employee and the Employee's attending Physician prior to the commencement of benefits.

(D) Maternity Leave Benefits are in lieu of Non-Occupational Short Term Disability Benefits. An Employee receiving Maternity Leave Benefits is not eligible to receive Non-Occupational Short Term Disability Benefits for the same pregnancy.

(E) Tax Withholdings: The Plan will follow Federal and State tax withholding rules when paying an Employee's weekly payment.

5. The Short-Term Disability Benefits schedule of Appendix A, Schedule of Benefits for the Active Plan of Benefits, is revised to read as follows:

SHORT TERM DISABILITY BENEFITS (For Employees Only)	
Non-Occupational Short Term Disability Benefits (Not work-related)	Weekly benefits include a payment up to $550 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational Short Term Disability Benefits (Work-related)	Weekly benefits include credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Maternity Leave Benefits	Weekly benefits include a payment of $800 and credit of up to 40 hours for a pregnancy or pregnancy-related condition certified by a Physician beginning no earlier than 26 weeks prior to expected delivery date (unless early delivery). Not to exceed a maximum of 26 weeks.

RESOLUTION AMENDING THE MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid America Carpenters Regional Council Health Fund (the "Fund") on May 21, 2025:

WHEREAS, Article XVIII section 18.01(A) of the Mid America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees and the Board of Trustees of the Carpenters' Health and Welfare Trust Fund of St. Louis ("STLKC Fund") entered into a Merger Agreement pursuant to which the STLKC Fund merged into the Fund effective March 31, 2025;

WHEREAS, the Merger Agreement provides that the Fund will maintain the STLKC Fund benefit package for the former STLKC participants and future participants in the Southern Region;

WHEREAS, the Trustees are taking action effective April 1, 2025 to amend the Plan to implement the merger of the STLKC Fund into the Fund;

WHEREAS, the Trustees are taking action effective May 1, 2025 to amend Appendix D – Southern Region Benefit Plan to revise the minimum difference rule and look back rule; and

WHEREAS, the Trustees are taking action effective July 1, 2025 to amend Appendix D – Southern Region Benefit Plan to add a maternity leave benefit, increase the short-term disability benefit and add a short-term disability benefit to the Basic Plan.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to reflect that the Trustees at their May 21, 2025 meeting resolved to amend the Plan by adopting Amendment No. 16, as set forth as Exhibit A attached hereto, effective as of the dates set forth therein.

Gary Perinar, Chairman — Date: 5/21/25

Gerald W. Thiel, Jr., Secretary — Date: 5/21/25

AMENDMENT NO. 16
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL
HEALTH FUND PLAN DOCUMENT

Effective as of the dates set forth herein, the Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective April 1, 2025, Article II, "Definitions," section 2.06, "Authorized Personal Representative," is amended to read as follows:

> "Authorized Personal Representative" means the person designated by a Claimant by means of the Fund's Authorized Personal Representative Form or Healthcare Power of Attorney to act on his behalf in receiving any information that is (or would be) provided to a Participant/beneficiary of the Plan, including but not limited to, any and all information that relates to his Claim for coverage or benefits under the Plan and any individual rights regarding his protected health information under HIPAA.

2. Effective April 1, 2025, Article II, "Definitions," section 2.12, "Claimant," is amended to read as follows:

> "Claimant" means a Covered Individual or Covered SRBP Individual who requests a benefit to be paid to him under the procedures set forth in Article XVI hereof. A Claimant includes an Authorized Personal Representative.

3. Effective April 1, 2025, Article II, "Definitions," section 2.27, "Covered Individual," is amended to read as follows:

> "Covered Individual" means a Participant, surviving spouse, and each Dependent eligible under the Active or Retiree Plans or an individual who elects continuation of Active Plan or Retiree Plan coverage under COBRA or the Low-Cost Medical Plan. For purposes of Articles XIV, Coordination of Benefits; XV, Subrogation and Reimbursement; XVI, Claims and Appeals; XVII, Privacy of Health Information, and Article XVIII, General Provisions; "Covered Individual" also means a Covered SRBP Individual.

4. Effective April 1, 2025, Article II, "Definitions," is amended to add a new section 2.28, entitled "Covered SRBP Individual," to read as follows:

> "Covered SRBP Individual" means a Participant, surviving spouse, and each Dependent eligible under the Southern Region Benefit Plan pursuant

to Appendix D or an individual who elects continuation of Southern Region Benefit Plan coverage under COBRA.

All subsequent sections and cross-references are updated accordingly.

5. Effective April 1, 2025, Article II, "Definitions," section 2.79, "Participant," is amended to read as follows:

"Participant" means an Employee employed or previously employed in Covered Employment who meets the eligibility requirements under Articles III and IV or Appendix D or an individual who elects continuation of Plan coverage.

6. Effective April 1, 2025, Article II, "Definitions," section 2.92, "Relevant," is revised to read as follows:

Information is "Relevant" if it:

(A) Was relied upon by the Claims Fiduciary in making the decision;

(B) Was submitted, considered, or generated regardless of whether it was relied upon; or

(C) Demonstrates compliance with Claim processing requirements.

Relevant information for purposes of Health and Short-Term Disability Claims includes but is not limited to:

(A) New or additional information considered, relied upon or generated during the appeal as well as any new or additional rationale for the denial, if any;

(B) Relevant internal rules, guidelines, protocol or other similar criteria;

(C) Explanation of the scientific or clinical judgment that formed the basis of the adverse benefit determination if the Claim is denied based on Medical Necessity, Experimental treatment or similar exclusion or limit; and

(D) The identity of any medical expert who provided a determination for a Claim.

7. Article II, "Definitions," section 2.95, "Retiree," is revised to read as follows:

"Retiree" means an individual, other than a Covered SRBP Individual, who worked for an Employer that paid Contributions to the Fund for the work performed in accordance with a written agreement requiring such Contributions, and is receiving a pension benefit from a Pension Fund. The term "Retiree" may also include retired Participants of other plans that merge into the Fund provided the Trustees have agreed to permit such individuals to qualify as "Retirees."

8. Article II, "Definitions," is revised to add a new section 2.102 to read as follows:

"Southern Region Benefit Plan" means the benefit plan described in Appendix D for individuals who qualify for and maintain eligibility for the Plan pursuant to Appendix D.

All subsequent sections and cross-references are updated accordingly.

9. The title of Article IV is revised to read as follows:

CONTINUATION COVERAGE

10. Effective April 1, 2025, Subsection (B) of Article IV, Continuation Coverage, section 4.01, Continuation Coverage under COBRA, is revised to add a new subsection (7) to read as follows:

(7) Southern Region Benefit Plan: The Southern Region Benefit Plan provides the option under which a Covered SRBP Individual may choose to pay for and receive coverage identical to the type of coverage in which the Covered SRBP Individual was enrolled while receiving benefits under the Plan.

11. Effective April 1, 2025, Subsection (F) of Article IV, Continuation Coverage, section 4.01, Continuation Coverage under COBRA, is revised to read as follows:

(F) 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:

(1) The Qualified Beneficiary fails to make timely Premium Payments under the Plan;

(2) The Qualified Beneficiary becomes covered under another health care plan that does not exclude coverage for preexisting conditions that are covered by this Plan;

(3) The Qualified Beneficiary becomes entitled to, eligible for, and enrolled in Medicare coverage; or

(4) The Trustees discontinue all eligibility under the Plan.

The Plan will provide a Qualified Beneficiary with a notice if there is an early termination of Continuation Coverage under COBRA.

12. Effective April 1, 2025, Subsection (A) of Article IV, Continuation Coverage, section 4.04, Low Cost Medical Plan, is revised to read as follows:

(A) As an alternative to Continuation Coverage under COBRA or USERRA coverage, an Employee may elect to continue health coverage under the Low Cost Medical Plan. Coverage for any Employee or Dependent under the Low Cost Medical Plan shall not exceed eighteen (18) consecutive months (or eighteen (18) months total when combined with prior Continuation Coverage under COBRA or Self-Payment of Hours) or twenty-four (24) months of consecutive coverage for USERRA coverage. Covered SRBP Individuals, retirees or their dependents are not eligible to elect the Low Cost Medical Plan. Health coverage benefits provided under the Low Cost Medical Plan are described in Appendix C. Health coverage is subject to change as a result of Plan modifications.

13. Effective April 1, 2025, Article XIV, Coordination of Benefits, section 14.02 is restated in its entirety to read as follows:

14.02 Coordination of Benefits with Medicare under the Active Plan of Benefits the Low Cost Medical Plan, and the Southern Region Benefit Plan

(A) Effect of Medicare for Covered Individuals: Health benefits under this Plan for Covered Individuals who are also eligible for Medicare will be paid as required by law. The benefits payable for a Covered Individual under this Plan will be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A or Part B will not exceed the total of allowable expense as defined by Medicare.

(B) This Plan will have primary responsibility for Medical Expenses incurred by a Covered Individual who is Medicare-eligible under the Active Plan, Low Cost Medical Plan or the Southern Region Benefit Plan if:

(1) Eligibility for Medicare is due to the Covered Individual being at least age sixty-five (65) or disabled and the Participant is employed by an Employer; or

(2) Eligibility for Medicare is due to End-Stage Renal Disease ("ESRD"). This Plan is primary for a period of thirty (30) months. However, if Medicare is primary for a Covered Individual due to age or Disability and then the Covered Individual becomes entitled to Medicare due to ESRD Medicare remains primary. A Covered Individual may have more than one (1) thirty (30) month period if he has a kidney transplant that subsequently fails, leading to a second transplant and a second (2nd) period of thirty (30) months.

(C) This Plan will have secondary responsibility for Medical Expenses incurred by a Covered Individual under the Active Plan, the Low Cost Medical Plan or the Southern Region Benefit Plan who is Medicare-eligible if:

(1) Eligibility for Medicare is due to the Covered Individual's being disabled or at least age sixty-five (65) and the Covered Individual does not have current employment status with an Employer as defined by Federal law, or

(2) Eligibility for Medicare is due to ESRD, but only after the first thirty (30) months of either sole or dual entitlement to Medicare due to ESRD (unless Medicare was already primary for the Covered Individual due to age or Disability).

If a Covered Individual is covered as an employee or dependent under more than one plan, then the plan covering the Covered Individual as an active employee or dependent of an active employee is primary over the plan covering the Covered Individual under COBRA or under the Plan's Low Cost Medical Plan. If a Covered Individual is also a Medicare beneficiary and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(3) Secondary to the plan covering the Covered Individual as a dependent; and

(4) Primary to the plan covering the Covered Individual other than as a dependent (e.g., a retired employee or COBRA beneficiary);

then the benefits of the plan covering the Covered Individual as a dependent are determined before those of the plan covering that person as other than as a dependent.

14. Effective April 1, 2025, Article XIV, Coordination of Benefits, section 14.04 is restated in its entirety to read as follows:

Section 14.04 Coordination of Benefits with Medicaid for the Active and Retiree Plans of Benefits, the Low Cost Medical Plan and the Southern Region Benefit Plan

The Plan honors any Medicaid assignment of rights made on behalf of a Covered Individual. The Plan also honors any reimbursement or subrogation rights that a state may have by virtue of payment of Medicaid benefits for Medical Expenses covered by the Plan. In addition, the Plan is primary and will not consider Medicaid eligibility or medical assistance provided by Medicaid in determining Plan benefits or eligibility.

15. Effective April 1, 2025, Subsections (B) and (C) of Article XVI, Claims and Appeals, section 16.04 are amended to read as follows:

(A) Short Term Disability Claims for benefits as described in Article X and Appendix D; and

(B) Other Benefit Claims, which include Life Insurance Benefits as described in Article XI and Appendix D and Accidental Death and Dismemberment Benefits as described in Article XII and Appendix D.

16. Effective April 1, 2025, Subsection (A) of Article XVIII, General Provisions, section 18.01, Amendment or Termination of the Plan and Trustee Discretion, is amended to read as follows:

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 Active Plan, the Retiree Plan, the Low Cost Medical Plan and the Southern Region Benefit Plan, at 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.

17. Effective April 1, 2025, Article XVIII, General Provisions, section 18.09, No Vested Right to Health and Welfare Benefits, is amended to read as follows:

> Coverage under the Plan does not confer any rights to or promise of continuing benefits for any Covered Individual or beneficiary. The benefits provided under the Active Plan, the Retiree Plan, the Low Cost Medical Plan, and the Southern Region Benefit Plan are not vested benefits.

18. Effective April 1, 2025, a new Appendix D, Southern Region Benefit Plan, is added to the Plan, to read as set forth in Exhibit A-1.

19. Effective May 1, 2025, the Look Back Rule on page 13 of Appendix D is revised to reduce the required look back hours effective with the May 1, 2025 hours, for the benefit quarter beginning October 1, 2025:

> **2. Look Back Rule**: Receipt of at least 1400 Credit Hours during the four (4) previous Contribution Quarters (12 months), will extend eligibility through the Benefit Quarter that next follows that Contribution Quarter.

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

20. Effective May 1, 2025, Minimum/Difference Self-Pays on page 15 of Appendix D is revised to increase the maximum number of payments effective with the May 1, 2025 hours, for the benefit quarter beginning October 1, 2025:

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

21. Effective July 1, 2025, the first paragraph of subsection A of Appendix D, Section D-VIII, Short-Term Disability Benefits, is revised to read as follows:

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

22. Effective July 1, 2025, Appendix D, Section D-VIII, Short-Term Disability Benefits, is revised to add a new subsection D, Maternity Leave Benefits, to read as follows:

> 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.

24. Effective July 1 2025, the Short-Term Disability Benefit Schedule in Appendix D, Section D-XII, Schedule of Benefits – Premium Plan is revised to read as follows:

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

25. Effective July 1, 2025, Appendix D, Section D-XII, Schedule of Benefits – Basic Plan is amended to add a Short Term Disability Schedule to read as follows:

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

EXHIBIT A-1

Appendix D

SOUTHERN REGION BENEFIT PLAN

This Appendix D sets forth the rules and benefits under the Southern Region Benefit Plan for Covered SRBP Individuals. All rules provided under the Plan apply to Covered SRBP Individuals except as specifically set forth in this Appendix D. For avoidance of doubt, the following Articles of the Plan apply to Covered SRBP Individuals:

Article I Establishment and Name of the Plan	Article XVI Claims and Appeals
Article IV Continuation Coverage	Article XVII Privacy of Health Information
Article XIV Coordination of Benefits	Article XVIII General Provisions
Article XV Subrogation and Reimbursement	Article XX Certification

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D-I. DEFINITIONS

Unless indicated otherwise in a specific context, words used in this Appendix D 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. The Definitions set forth in Article II apply to the Southern Region Benefit Plan as specifically identified in this Appendix D.

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 Employee 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 a QMCSO.

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, 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**" 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:

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

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

        3) 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. **"Claims Fiduciary"** see Section 2.13.

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

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

17. **"Collective Bargaining Agreement"** or **"CBA"** is the written legal contract between the Union and an Employer providing for contributions to the Plan.

18. **"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:

        1) undergoing a course of institutional or inpatient care from the Provider;

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

3) Is pregnant and undergoing a course of treatment for the pregnancy from the Provider;

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

19. **"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.

20. "Contracted Provider" see Section 2.19.

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

22. **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.

23. **"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.

24. **"Covered Employment"** means work performed by an Employee for an Employer for which contributions for hours worked are required to be made to the Fund under a CBA, Participation Agreement, or other written agreement.

25. **"Covered Person"** is a Participant and/or Dependent, who is eligible for benefits under the Plan in accordance with this Article D-II of this Appendix D.

26. **"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.

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

28. **"Dependents"** are a Participant's Child or Spouse.

29. **"Durable Medical Equipment"** means equipment that meets all the following conditions:

    (a) It can withstand repeated use.

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

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

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

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

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

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

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

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

31. **"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.

32. **"Emergency"** see Section 2.41.

33. **"Emergency Room"** see Section 2.42

34. **"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.

35. **"Employee"** see Section 2.44.

36. **"Employer"** see Section 2.45.

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

38. **"ERISA"** see Section 2.46.

39. **"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.

40. **"Experimental or Investigative"** means in connection with a drug, device, treatment, or procedure that:

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

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

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

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

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

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

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

42. **"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.

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

44. "Home Health Agency" see Section 2.54.

45. **"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.

46. **"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.

47. **"Hospital"** means a legally operated institution that meets one of the following requirements:

    (a) It is accredited as a Hospital by the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations, is supervised by a staff of Physicians and provides 24-hour-a-day nursing service and it is primarily engaged in providing either:

    (b) general inpatient care and treatment of Illness or Injury through medical, diagnostic, and major surgical facilities on its premises, or

    (c) specialized treatment for mental and nervous disorders.

    (d) It is an approved nonresidential chemical dependency treatment center licensed by the jurisdiction (state, District of Columbia, territory, or possession of the United States, or province of Canada) in which it is domiciled and is providing outpatient treatment to a Covered Individual.

48. **"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.

49. **"Illness"** see Section 2.57. All Illnesses that are due to the same or related cause or causes will be deemed one Illness.

50. **"Injury"** see Section 2.59.

51. **"In-Network Provider," "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.

52. **"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.

53. **"Medically Necessary"** or **"Medical Necessity"** means those services, supplies, equipment, and facility charges that are not expressly excluded under the Plan and are determined to the Plan to be:

    (a) Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks.

    (b) Necessary to meet health needs, improve physiological function and required for a reason other than improving appearance.

    (c) Rendered in the most cost-efficient manner and setting appropriate for the delivery of the Health Service.

    (d) Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research, professional medical specialty organizations or governmental agencies generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested.

    (e) Consistent with the diagnosis of the condition at issue.

    (f) Required for reasons other than the comfort of the Covered Individual or the comfort and convenience of the Physician.

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

54. **"Medicare"** see Section 2.68.

55. **"Network Sponsor"** see Section 2.71.

56. "No Surprises Act" see Section 2.72

57. **"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.

58. **"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)

59. **"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.

60. **"Non-Pension Participant"** means a Participant who is not eligible to participate in the Carpenters' Pension Plan but is eligible to participate in the Health and Welfare Plan due to a Participation Agreement or CBA.

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

62. "Out-of-Network" or "Non-Network Provider" see Section 2.73.

63. "Out-of-Pocket Maximum" see Section 2.77.

64. **"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.

65. "Participation Agreement" see Section 2.80.

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

67. **"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.

68. **"Physician"** see Section 2.84.

69. **"Plan"** see Section 2.85.

70. **"Plan Year"** see Section 2.86.

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

72. **"Premium"** is the monthly fee required for certain classes of coverage under the Plan, as determined by the Trustees from time to time.

73. **"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.

74. **"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).

75. **"Primary Care Physician"** (PCP) refers to a physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. Internal

Medicine, Family Physician, OB-GYN, Pediatrician, Doctor of Osteopathy and General Medicine physicians are all considered Primary Care Physicians under the Plan.

76. **"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.

77. "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.

78. **"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.

79. **"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.

80. **"Retired Participant"** means an individual who meets all of the following requirements

    (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 retired Non-Pension Participant, a Disabled Participant, nor a Surviving Spouse.

81. **"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.

82. **"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.

83. **"Spouse"** see Section 2.33(A)

84. **"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.

85. **"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.

86. **"Trust Agreement"** see Section 2.105.

87. **"Trust Fund"** or **"Fund"** see Section 2.50.

88. **"Trustees"** see Section 2.106

89. **"Union"** see Section 2.108

D-II. ELIGIBILITY & ENROLLMENT

This Section sets forth the rules for determining eligibility for 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.

6. 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 Apprentices during their first four years, are enrolled as a Participant in the Premium Benefit 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 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 Fund 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 a 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.

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 (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

CONTRIBUTION QUARTERS (When hours are worked)	Hours Needed	Two-Month Processing Period	BENEFIT QUARTERS (When coverage is granted)
February March April	330	May June	July August September

2. **Look Back Rule**: Receipt of at least 1440 Credit Hours during the four (4) previous Contribution Quarters (12 months), will extend eligibility through the Benefit Quarter that next follows that Contribution Quarter.

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

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 and welfare 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 – 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, a 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's 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 can reinstate eligibility as follows:

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 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 self-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 two Benefit Quarters within an 18-month period. These two 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:

1. 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.

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

3. 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.

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

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

6. 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. Participants enrolled in the Medicare Advantage Program can purchase Dependent coverage in the Non-Active Classification. 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 the 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: 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 Medicare Advantage Program.

The Medicare Advantage Program fully insured by the Plan's Contracted Provider. The Plan's monthly charge for an individual who participates in the Medicare Advantage Program includes 100% of the Premium due from the individual to the Contracted Provider.

To participate in the Medicare Advantage Program, an individual must also be enrolled in Medicare Parts A and B, and must enroll in the 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 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 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 the Non-Active Classification 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 a 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 the Non-Active Classification.

A Bargained Participant who loses Active eligibility as a result of acquiring employment in a non-bargained position by a 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 the Non-Active Classification only if:

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

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

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

   (a) Months in which the Participant performed bargaining unit work for a 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 for 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 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 a 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 the Non-Active Classification 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 the Non-Active Classification 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; and

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

   (a) Months in which the Participant performed bargaining unit work for a 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 the Non-Active Classification.

A Participant cannot become eligible for the Non-Active Classification 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 a 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 and welfare Credit Hours during Non-Active coverage will receive a refund or credit against their self-payment, up to the amount of the Employer contributions received by the Plan. The credit or refund for hours worked in a month will not exceed the amount of the self-payment applicable for that benefit month.

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

1. The Participant must notify the Benefit Office in advance of the intent to have Credit Hours applied to reinstate Active Classification coverage, in which case Employer contributions for the Participant will cease to be credited against self-payments and will begin to be credited toward Active Classification eligibility.

2. If the loss of prior Active Classification coverage has not exceeded 24 months, the Participant must satisfy the Quarterly Eligibility rule within those 24 months to reestablish coverage, otherwise, the Participant must meet the Initial Eligibility rule.

3. Only Credit Hours earned during Non-Active coverage as provided above will be applied to satisfy eligibility requirements.

4. A Participant may move from Non-Active to Active coverage only once, except that a Participant with Non-Active coverage by virtue of Total and Permanent Disability who ceases to be Totally and Permanently Disabled is not bound by this limitation.

Notwithstanding the forgoing, a Participant enrolled in the Medicare Advantage Program who receives sufficient health and welfare 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.

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 thirty (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 thirty (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 ninety (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 ninety (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 thirty-one (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 sixty (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.

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

   (b) 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.

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

6. 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.

7. 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.

8. The date the Plan terminates.

D-III. COMPREHENSIVE MEDICAL BENEFITS

The Plan provides coverage for Covered Expenses as specified in this Article D-III and in the applicable Schedule of Benefits incurred as a result of a non-occupational Illness or Injury. For Medicare Eligible Individuals, benefits will be coordinated with Medicare as described in Article XIV, Section 14.02 and 14.03. Benefits are subject to the Deductible, Coinsurance and Co-payment and considered up to the amounts determined by the Trustees from time to time and in accordance with the limitations as specified below and in the Schedule of Benefits. The following conditions apply:

A. 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.

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.

B. 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.

C. 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 access to specialized nurses and high-performing providers to help meet a Covered Person's specific needs from early pain onset through treatment and beyond for joint-related conditions. This program offers:

- Early intervention and appropriate care.
- Coaching to support behavior change.
- Shared decision-making.
- Pre- and post-surgical counseling.
- Support in choosing treatment options.
- Education on back-related information and self-care strategies.
- Long-term support.
- Access to Designated Providers.

D. 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.

1. Abortion:

   (a) The Plan covers abortion 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.

   (b) Prior authorization is required.

   (c) The Plan excludes elective abortions.

2. Allergy Care:

   (a) The Plan covers allergy testing, diagnosis, treatment, allergy serum,

administration of injections and sublingual drops, and prescribed medications.

(b) Services and supplies not administered by a Physician, such as, but not limited to, air filters, air purifiers, or air ventilation system cleaning.

3. Ambulance Service:

(a) 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.

(b) Emergency air or water medical transport service is an exceptional circumstance, covered only if all the above-stated criteria pertaining to ground transportation are met as well as any one or more of the following:

1) The patient's medical condition is such that the time needed to transport the patient by land poses a significant threat to the patient's health or life and requires immediate and rapid ambulance transport that could not be provided by land ambulance; or

2) The point of pickup is inaccessible to a land vehicle; or

3) Great distances, limited time frames, or other obstacles to land transport would prevent getting the patient to the nearest Hospital with appropriate facilities for treatment.

(c) Prior Authorization is required for non-emergent transportation from one Hospital or medical facility to another.

(d) Emergency air or water transport is covered only for the lowest cost aircraft or vessel available and appropriate for the patient's medical condition.

(e) The Plan excludes all ambulance transportation services for which the required criteria are not met, including, transportation that is primarily for repatriation (e.g., to return the patient to the United States)

4. Anesthesia:

(a) The Plan covers anesthesia administered by a Physician or qualified Allied Health Professional.

(b) The Plan excludes Anesthesia in conjunction with non-covered medical or surgical procedures.

5. Assistant Surgeon:

(a) The Plan covers 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.

(b) 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.

6. Autism Spectrum Disorders (ASD) Treatment:

(a) The Plan covers diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

(b) The Plan excludes services or treatment identified elsewhere as 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)

7. Blood and Blood Products:

(a) The Plan covers administration, storage and processing of blood and blood products in connection with covered services and supplies.

(b) The Plan excludes:

1) Harvesting and storage of a patient's own blood, except for potential use in a covered, scheduled surgical procedure.

2) Fetal cord blood harvesting and storage

8. Bracytherapy is covered. Prior authorization required.

9. Cardiac Diagnostic Testing:

(a) The Plan covers 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.

(b) Prior authorization required.

10. Cardiac Rehabilitation Therapy:

(a) The Plan covers Cardiac Rehabilitation programs if referred by a Physician, for patients who have certain cardiac conditions. Covered services include:

1) Phase I cardiac rehabilitation, while the Covered Person is an inpatient

2) 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.

(b) Benefits limited to 60 visits per year.

11. Cataract or Aphakia Surgery:

(a) The Plan covers cataract or aphakia surgery, including:

1) Surgically implanted conventional intraocular cataract lenses following

such a procedure.

2) Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery.

(b) The Plan excludes multifocal intraocular lenses.

12. Chemotherapy and Radiation Therapy:

(a) The Plan covers standard chemotherapy and radiation therapy, including Intensity Modulated Radiation Therapy (IMRT), Stereotactic Radiation Therapy, Proton Beam Therapy, and dose-intensive chemotherapy.

(b) Prior authorization required.

13. Chiropractic Services:

(a) The Plan covers chiropractic services performed by a chiropractor or other appropriately licensed Provider, including services for diagnosis by physical examination and plain film radiography for treatments for musculoskeletal conditions.

(b) Benefits limited to 40 visits per calendar year per Covered Person

(c) The Plan excludes services performed for Maintenance.

14. Circumcision and related expenses are covered.

15. Cleft Palate and Cleft Lip:

(a) The Plan covers initial and staged reconstruction of cleft palate or cleft lip.

(b) Coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

16. Clinical Trials:

(a) The Plan covers routine patient care incurred as a result of enrollment in Phase I, II, III or IV clinical trials undertaken for the purposes of the prevention, early detection, or treatment of cancer, if the clinical trial is conducted at an academic or NCI center and is approved or funded by one the following entities:

1) National Institute of Health (NIH).

2) An NIH cooperative group or center.

3) The FDA in the form of an investigational new drug application.

4) The federal Departments of Veterans' Affairs or Defense.

5) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

6) An institutional review board that has an appropriate assurance approved by the Department of Health and Human Services

(b) Prior authorization required.

(c) The Plan excludes:

1) Care that does not meet the stated criteria;

2) Non-health care services required in conjunction with the clinical trial (such as transportation, lodging, Custodial Care);

3) Services and supplies provided to enrollees in the clinical trial without charge;

4) Services required to conduct, manage and administer the clinical trial or to collect and analyze data; and

5) Supplies and services that would not be covered for reasons other than being Experimental or Investigative.

17. Corneal Transplants are covered.

18. Cosmetic, Plastic and Related Reconstructive Surgery:

(a) The Plan covers the following cosmetic surgeries:

1) 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;

2) replacement of diseased tissue surgically removed, within one year of the surgery or as soon thereafter as medically appropriate;

3) treats a birth defect in a Child as soon as medically appropriate; and

4) breast reconstruction following a covered mastectomy.

(b) Prior authorization is required.

(c) The Plan excludes:

1) Services or supplies that are not obtained as soon as medically appropriate.

2) 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.

19. Dental Services:

(a) The Plan covers the following dental services:

1) 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

2) 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.

3) 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.

(b) Prior authorization is required.

(c) The Plan excludes:

1) Care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial),

2) Root canal,

3) Surgery for impacted teeth,

4) Surgery involving structures directly supporting the teeth,

5) Dental implants or orthodontia,

6) Oral surgical procedures (including services for overbite or under bite), whether the services are considered to be medical or dental in nature,

7) Dental x-rays, supplies, and appliances (including occlusal splints and orthodontia),

8) Removal of dentigerous cysts,

9) Mandibular tori and odontoid cysts, and

10) Removal of teeth due to an Injury, prior to radiation or for radionecrosis,

The Plan may cover such services under the Dental Benefit.

20. Dermatological Care:

(a) The Plan covers 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.

(b) The Plan excludes all cosmetic procedures except as specifically stated.

21. Diabetic Supplies:

(a) The Plan covers glucose meters, insulin pumps and cartridges, diabetic shoes, and self-management training used in connection with the treatment of diabetes.

(b) Prior authorization is required.

(c) The Plan excludes disposable insulin syringes, glucose strips, and lancets are not covered in the Medical Benefit, but may be covered under the Prescription Drug Benefit.

22. Diagnostic and Treatment Services:

(a) The Plan covers the following services when performed by a Physician, whether in our out of the Physician's office:

1) Diagnosis and treatment of covered Illness or Injury.

2) Administration of Injectable medication normally rendered in a Physician's office.

3) Consultations with specialists.

4) Performance of laboratory tests.

23. Dialysis:

(a) The Plan covers hemodialysis and peritoneal services provided by outpatient or inpatient facilities, or at home only if patient is homebound.

(b) For home dialysis, equipment, supplies, and maintenance are covered.

(c) Prior authorization is required.

24. Durable Medical Equipment (DME):

(a) The Plan covers DME that is Medically Necessary for the treatment of an Illness or Injury or to improve the functioning of a malformed body part.

(b) 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

(c) Prior authorization is required.

(d) Upgrades to equipment are not covered unless Medically Necessary due to change in the patient's condition.

(e) 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.

(f) The Plan excludes:

1) Equipment that does not satisfy all stated criteria to qualify as DME, including, but not limited to, exercise equipment, air purifiers, central or unit air conditioners, humidifiers and dehumidifiers, allergenic pillows or mattresses and water beds, regardless whether prescribed by a Provider.

2) Equipment that is superior to other alternatives primarily because of comfort or convenience, regardless whether prescribed by a Provider.

25. Durable Medical Equipment Supplies:

(a) The Plan covers non-disposable supplies needed for use of covered Durable Medical Equipment.

(b) Supplies related to a TENS unit are only covered with the initial purchase of the TENS unit.

(c) The Plan excludes over-the-counter and all disposable supplies.

26. Emergency Services:

(a) The Plan covers Emergency Services.

(b) The Plan also covers services and supplies furnished or required to screen and stabilize an Emergency medical condition, when provided on an inpatient or outpatient basis at either a Hospital or Physician services in a provider's office, when traveling outside the United States.

(c) The Plan excludes non-Emergency services received in an Emergency Room.

27. Eye refractions are covered if related to a covered medical condition.

28. Genetic Testing and Counseling:

(a) The Plan covers genetic testing that meets the following requirements:

1) The test must not be considered Experimental, Investigational, or Unproven.

2) The test must be performed by a CLIA-certified laboratory. T

3) he test result must directly impact or influence the disease treatment of the Covered Person.

4) Genetic testing must also meet at least one of the following:

(i) The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).

(ii) Conventional diagnostic procedures are inconclusive.

(iii) The patient has risk factors or a particular family history that indicates a genetic cause.

(iv) The patient meets defined criteria that place them at high genetic risk for the condition.

(b) Prior authorization required.

29. Hearing Services:

(a) The Plan covers one hearing examination per year; and tests, services and supplies to diagnose and treat a medical condition.

(b) Hearing Aid devices are covered subject to a limit of $2,000 per ear every five years.

(c) Hearing exams are available to Dependents as part of routine and diagnostic benefits.

(d) Hearing Aid devices are available only to Participants in the Active classification and non-Medicare Retired Participants. No coverage for Dependents.

30. Home Health Services:

(a) The Plan covers home health services delivered through a Home Health Agency when 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.

(b) Prior authorization required.

(c) Coverage limited to 100 visits per calendar year. A visit is defined as four hours or less.

31. Hospice:

(a) The Plan covers treatment at a Hospice Care Facility in place of a stay in a Hospital or Extended Care Facility.

(b) Coverage may include:

1) 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.

2) 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.

3) 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.

4) 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.

32. Hyperbaric Oxygen Therapy (HBOT):

(a) The Plan covers hyperbaric oxygen therapy.

(b) Prior authorization is required.

33. Implants and Related Services:

(a) The Plan covers implanted devices and related services, including: pacemakers, joint replacements, AEDs, implantable TENS units, spinal braces, penile implants, and implants for the delivery of prescription medication.

(b) Repair and maintenance of prior implants is covered when Medically Necessary subject to Prior Authorization.

(c) Prior authorization is required.

(d) The Plan excludes replacement of covered implants is not covered, except when Medically Necessary due to a change in the patient's condition related to the implant.

34. Impotence:

(a) The Plan covers diagnosis and treatment of impotence.

(b) Prior authorization of any surgical treatment is required.

35. Infertility:

(a) The Plan covers diagnostic studies up to the point of an infertility diagnosis.

(b) Prior authorization is required.

(c) The Plan excludes treatment of infertility.

36. Injectable Medications:

(a) The Plan covers 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.

(b) The Plan excludes self-injectable medications (though coverage may be available under the prescription drug benefit).

37. Inpatient Hospital Care:

(a) The Plan covers:

1) Semi-private (or private if semi-private not offered) accommodations, Intensive Care Unit, or Coronary Care Unit, as appropriate;

2) General nursing care;

3) Use of operating room, surgical and anesthesia services and supplies;

4) Blood and blood products;

5) Ordinary casts, splints and dressings;

6) All drugs and oxygen used in the Hospital;

7) Laboratory and X-ray examinations; and

8) Electrocardiograms.

(b) Prior authorization is required, except for the first 48 hours (vaginal delivery) or 96 hours (cesarean section) of a maternity admission.

(c) All Acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay.

(d) 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.

(e) Coverage is for the lowest level of care that is Medically Necessary and will cease if inpatient care is no longer Medically Necessary.

(f) The Plan excludes 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.

38. Laboratory Services:

(a) The Plan covers laboratory services within the standards of care for the particular diagnosis.

(b) Coverage is limited to services that are less costly and likely to produce results equivalent to the prescribed services, when clinically appropriate.

(c) The Plan excludes laboratory services in excess of the standard of care.

39. Maternity and Pregnancy Services:

(a) The Plan covers maternity-related medical, Hospital and other covered services and supplies for the mother and her newborn Child, including up to forty-eight (48) hours of inpatient post-natal maternity care for vaginal delivery and ninety-six (96) hours of inpatient post-natal maternity care for cesarean

delivery.

(b) If there is a shorter length of stay, post-discharge care is covered as follows: Up to two (2) visits, at least one (1) of which may be in the home, in accordance with maternal and neonatal physical assessments, by a Physician or a registered professional nurse with experience in maternal and child health nursing.

(c) Services of certified and licensed midwives are covered in the states in which they practice.

(d) 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.

(e) Pregnancy is covered on the same basis as any Illness or Injury.

(f) The Plan excludes home delivery except in an Emergency.

40. Medical Complications:

(a) The Plan covers complications arising from a covered surgical procedure.

(b) The Plan excludes:

1) Complications following a covered surgical procedure resulting from failure to follow the prescribed course of treatment, and

2) Complications arising from a service or supply not covered by the Plan.

41. Medical Services in a Physician's Office:

(a) Medical services performed as part of a Physician's Office Visit are generally covered as part of the copay for the Office Visit.

(b) This includes surgeries and diagnostic tests conducted as part of the Office Visit.

42. Member Assistance Program (MAP):

(a) The Plan provides confidential counseling services in the following areas, regardless of whether Medically Necessary, if obtained in the Plan's Member Assistance Program

1) Stress Management

2) Legal problems

3) Positive drug/alcohol test

4) Marital and family counseling

5) Parenting

6) Anxiety, depression, and grief

(b) MAP services are available only through the Mercy Member Assistance Program which is a part of the Mercy Managed Behavioral Health Network.

(c) Coverage is limited to six visits per episode.

43. Mental Health and Substance Use Disorder Services:

(a) The Plan covers services and supplies for diagnosis and treatment of mental health and substance use disorders.

(b) Prior authorization is required for all facility services.

44. Morbid Obesity Treatment:

(a) The Plan covers only the following treatments if Medically Necessary and appropriate for an individual's Morbid Obesity condition:

1) Bariatric surgery, including, but not limited to Gastric or intestinal bypasses, stomach stapling, lap band, gastric sleeve procedure;

2) charges for diagnostic services and nutritional counseling by registered dieticians or other Providers.

(b) Prior authorization is required.

(c) The Plan excludes diet supplements and exercise equipment.

45. Newborn Inpatient Care After Discharge of Mother:

(a) The Plan covers services and supplies, which are otherwise covered, for care of neonates.

(b) Services and supplies for diagnosis and treatment of conditions unique to newborns are covered, 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.

(c) Prior authorization is required.

(d) The Plan excludes transportation of newborn to another facility when the current facility is appropriately staffed and equipped to treat the newborn's condition.

46. Nutritional Supplements, Enteral and Parenteral Feedings, Vitamins and Electrolytes:

(a) The Plan covers nutritional supplements, enteral and parenteral feedings, vitamins, and electrolytes that are prescribed by a Physician and administered through a tube or taken orally, provided they meet the following criteria:

1) They are the sole or partial source of nutrition, as determined medically necessary by a Physician for a specified period.

2) They are part of a chemotherapy regimen.

(b) 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.

(c) Prior authorization is required for enteral and parenteral feeding.

(d) The Plan excludes 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.

47. Office Visits:

(a) The Plan covers services and supplies appropriately provided during an office visit by a Physician, including but not limited to

1) Diagnosis and treatment of Illness or Injury.

2) Injectable medication that requires supervision from a health care professional and is normally rendered in a Physician's office.

3) Diagnostic tests (for example X- ray and lab) and surgeries performed during the office visit.

(b) The Plan excludes self-injectable medications and specialty injectable medications.

48. Oral Surgery and Diseases of the Mouth:

(a) The Plan covers:

1) 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.

2) 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.

3) 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.

4) Diseases of the mouth, except dental disease or disease of dental origin.

(b) Prior authorization is required.

(c) The Plan excludes:

1) Dental diseases, and services and supplies covered in the Plan's Dental Benefit.

2) 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.

49. Orthotics for Feet:

(a) The Plan covers custom made foot orthotics.

(b) Replacement orthotics are also covered provided the replacement is prescribed by a Physician and Medically Necessary due to a change in the patient's physical condition.

(c) Prior authorization may be required.

(d) The Plan excludes over-the-counter orthotics or other inserts not custom made for the patient.

50. Outpatient Diagnostic Tests and Therapeutic Treatments:

(a) The Plan covers 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.

(b) Prior authorization is required Prior Authorization is required for those diagnostic tests and therapeutic treatments so specified in a list maintained by the Plan.

51. Observation Services:

(a) The Plan covers observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less.

(b) 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.

52. Outpatient Surgery:

(a) The Plan covers services and supplies for prescheduled outpatient surgery performed at a Hospital or Alternate Facility under the direction of an attending Physician.

(b) Prior authorization is required for those outpatient surgical procedures specified in a list maintained by the Plan.

(c) The Plan excludes Experimental or Investigational surgical procedures or devices used as part of the surgery.

53. Pain Management:

(a) The Plan covers pain management services and supplies, pain management injections (including epidural, trigger point and facet injections).

(b) Prior authorization is required.

54. Phenylketonuria (PKU) or other Amino and Organic Acid Inherited Disease Formula and Food:

(a) The Plan covers formula and low protein modified food products used for PKU or any other amino and organic acid inherited disease when prescribed by a Physician.

(b) Prior authorization is required.

(c) Coverage is limited to children under the age of six.

55. Podiatry:

(a) The Plan covers services that are recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

1) Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.

2) 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.

3) Physician office visit for diagnosis of bunions.

4) The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed

(b) The Plan excludes the following:

1) Palliative Footcare

2) 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.

3) Over the counter inserts.

4) Trimming of nails, corns, or calluses when there is not a metabolic disease (routine foot care).

56. Preventive Care:

(a) The Plan covers Preventive services regardless of Medical Necessity.

(b) The ACA Preventive Care Recommendations are incorporated herein by reference, and the provisions of this subsection hall be interpreted accordingly. Covered Preventive services shall be automatically amended as necessary from time to time to conform to future changes in the Preventive Recommendations.

(c) Breast pumps are limited to the lesser of cost of purchase or rental of one pump per pregnancy in conjunction with childbirth.

(d) All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. The following contraceptives will be processed under the medical Plan:

1) Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.

2) Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

57. Prosthetic Devices:

(a) The Plan covers:

1) 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.

2) For placements requiring a temporary, followed by a permanent, placement only one (1) device will be covered.

3) 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.

4) For breast prosthetics, replacement will be covered if determined necessary by the patient's Physician.

5) Splints and braces, other than dental braces, are covered, including necessary adjustments to shoes to accommodate leg braces.

(b) Prior authorization for prosthetic devices over $10,000, and for refitting or replacements.

(c) The Plan excludes over-the-counter braces, splints, and prostheses.

58. Pulmonary Rehabilitation Therapy:

(a) The Plan covers pulmonary rehabilitation therapy.

(b) Coverage limited to a maximum of 60 days per calendar year, combined (In-

and Out-of-Network) with all other therapies, including Cognitive Therapy and Pulmonary Rehabilitation Therapy.

59. Radiology:

(a) The Plan covers radiology services and supplies.

(b) Prior authorization is required for those radiology services and supplies specified in a list maintained by the Plan.

60. Reconstructive Surgery:

(a) The Plan covers 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.

(b) The Plan excludes reduction or augmentation mammoplasties that are not Medically Necessary and are unrelated to a Medically Necessary mastectomy.

61. Rehabilitation Services and Supplies Visits:

(a) The Plan covers therapy prescribed by attending Physician, and provided in an outpatient setting by a Provider within the scope of their respective licenses, including:

1) Occupational therapy by a occupational therapist (OT) or other appropriately licensed Provider.

2) Physical therapy by a physical therapist (PT) or other appropriately licensed Provider.

3) Respiratory therapy by a respiratory therapist (RT) or other appropriately licensed Provider.

4) Aquatic therapy by a physical therapist (PT), aquatic therapist (AT), or other appropriately licensed Provider.

5) 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, 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.

(b) 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.

(c) 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

(d) Coverage limited to a maximum of 60 days per calendar year, combined.

(e) The Plan excludes:

1) Rehabilitative services provided for long-term, chronic medical conditions.

2) 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.

3) Educational or vocational therapy designed to retrain patient for employment.

4) Alternative rehabilitation services such as massage therapy.

5) 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

62. Second Surgical Opinion:

(a) The Plan covers a second surgical opinion if given by a board-certified specialist in the medical field related to the surgical procedure being proposed.

(b) The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

63. Sclerotherapy:

(a) The Plan covers treatment of varicose veins.

(b) Prior authorization is required.

64. Skilled Nursing Facility Services:

(a) The Plan covers confinement in a skilled nursing facility, together with medical services and supplies provided in the facility, for care and treatment that cannot be safely or effectively provided in an outpatient setting, as determined by the Plan.

(b) Prior authorization is required.

(c) Coverage is limited to a maximum of 100 days per calendar year per Covered Person and semi-private accommodations.

65. Sleep Studies and Sleep Disorders:

(a) The Plan covers sleep studies to diagnose obstructive sleep apnea are covered and treatment for sleep disorders if medically necessary.

(b) Prior authorization is required for outpatient or facility studies.

66. Sterilization:

(a) The Plan covers vasectomy regardless of Medical Necessity and tubal ligation as a Preventive service.

(b) The Plan excludes reversals of vasectomy.

67. Surgeon Services:

(a) 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.

(b) Prior authorization is required.

68. Temporomandibular Joint Disorder (TMJ) Services:

(a) The Plan covers:

1) Diagnosis and surgical treatment for TMJ and craniomandibular joint disorder.

2) 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.

(b) Prior authorization is required for any surgical procedure.

(c) The Plan excludes orthodontic treatment of TMJ, and orthodontic appliances for such treatment.

69. Transplant Travel Benefits:

(a) The Plan covers travel benefits for an organ transplant for a Participant and Spouse or significant other and the living donor.

(b) Travel benefits include lodging, meal charges and transportation to and from a facility for evaluation and transplant services.

(c) Benefits are subject to the following conditions:

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.

(d) 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.

(e) The cost of gasoline will only be covered or reimbursed, as appropriate, and mileage will no longer be eligible for reimbursement.

(f) Reasonable expenses as determined by the Trustees are covered for parking, taxi, and shuttle buses.

(g) Prior authorization is required.

(h) Benefit limited to $10,000 per transplant and includes the Participant and living donor.

(i) 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.

(j) 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.

(k) Air travel is limited to the transplant Participant, plus one other person or for both parents if for child transplant Participant.

70. Transplant and Related Transplant Therapies:

(a) The Plan covers services and supplies for organ transplants only if obtained in the Plan's Transplant Network.

(b) 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 Contracted Provider approved stem cell transplant program.

(c) Prior authorization is required.

(d) The Plan excludes:

1) Any transplant service by a Provider outside of the Transplant Network.

2) Any advanced cellular therapy by a Provider outside of the approved Transplant Network.

71. Urgent Care Services are covered when provided at an Alternate Facility such as an urgent care center.

72. Virtual Office Visits:

(a) The Plan covers virtual office visits, or telehealth, with a Physician.

(b) The Plan covers telemedicine services, through Teledoc.

73. Vision Therapy:

(a) The Plan covers vision therapy when Medically Necessary to treat convergence insufficiency.

(b) Coverage is limited to a diagnosis of convergence insufficiency.

74. Walk-In Retail Health Clinics are covered.

75. Wellness Center Services sponsored by the Fund are covered.

E. 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 D 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 a Illness or Injury or other condition that is court-ordered or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while- intoxicated conviction or other classes ordered by the court.

6. Acupuncture services and associated expenses of any kind, including, but not limited to, treatment of painful conditions or for anesthesia purposes.

7. Allergy Services – Non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.

8. Alternative Therapies – Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies, hypnosis, homeopathic therapies and any related diagnostic testing.

9. Assistance with Activities of Daily Living

10. Autopsy – Services and associated expenses related to the performance of autopsies.

11. Before Enrollment and After Termination – Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

12. Biofeedback services

13. Blood Donor expenses

14. Blood Pressure Cuffs/Monitors unless prescribed by an authorized provider.

15. Braces or supports needed solely for athletic participation or employment.

16. Cardiac Rehabilitation – Beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

17. Charges over 12 months old from the incurred date when submitted for consideration to the Plan.

18. Cosmetic or reconstructive procedures and any related services or supplies which alter appearance but do not restore or improve impaired physical function, except as expressly listed in as a Covered Service under Cosmetic, Plastic and Related Reconstructive Surgeries.

19. Counseling – Services and treatment related to financial counseling, family planning counseling, religious counseling, marital and relationship counseling, vocational or employment counseling and sex therapy, except as expressly listed in Covered Services or as provided in the Member Assistance Plan.

20. Custodial Care not rendered during a covered inpatient admission, including, but not limited to, non-medical domiciliary care, respite care, rest care, or similar services primarily assisting Covered Persons in the activities of daily living such as walking,

getting in and out of bed, bathing, dressing, feeding, using the toilet. Also excluded, except during a covered inpatient admission, are preparation of special diets, supervision of medication usually self- administered, and any health-related services except covered Hospice that do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or that do not require continued administration by trained medical personnel.

21. Duplicate Services and Charges or Inappropriate Billing – including preparation of medical reports and itemized bills.

22. Educational Services – Educational services for remedial education.

23. Equipment or services for use in altering air quality or temperature.

24. Elective or Voluntary Enhancement – Elective or voluntary enhancement procedures, services, and medications provided to improve weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging performance, including, but not limited to, growth hormone, testosterone, salabrasion, laser surgery or other skin abrasion procedures associated with the removal of scars or tattoos.

25. Electrical continence aids; anal or urethral

26. Enteral Feeding Food Supplement – The cost of outpatient enteral tube feedings or formula and supplies, except as expressly listed in Covered Services. Over the counter supplements and supplies are excluded.

27. Examinations conducted for purposes of medical research or to obtain or maintain a license of any type or for employment or litigation purposes, including physical, psychiatric, or psychological examinations or testing, vaccinations, immunizations, or treatments.

28. Excess Charges – Charges or the portion thereof that are in excess of the 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 on the wrong person, objects left in patients after surgery, or other similar situations.

D-IV. WELLNESS CENTER

A. 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.

B. AVAILABLE SERVICES

<u>Available Services in St. Louis</u>

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

Available Services in Kansas City

Services available at the Kansas 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

C. 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.

D-V. PRESCRIPTION DRUGS

A. LEVELS OF BENEFIT

The Plan’s Prescription Drug Benefit provides benefits for Medically Necessary prescription drugs, and also for some Preventive medications. Both the Premium and Basic Plan have the

same prescription drug coverage.

B. COVERED DRUGS

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

1. Prescribed by a Physician; and

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

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

4. Medically Necessary, except for Preventive drugs; and

5. 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.

C. SPECIAL COVERAGE LIMITATIONS

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

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.

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

Step Therapy Programs

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

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. When Covered Individuals enroll in this program there is no Copay for the Select Specialty Medication. If the Covered Person does not enroll in this 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. The Contracted Provider 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. 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 Preventive drugs or 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.

D-VI. DENTAL

The Dental Benefit is self-funded by the Plan. The Plan has contracted with the Network Sponsor to process dental claims, to make Prior Authorization determinations, and for access to the Dental Network. 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.

Premium Plan Dental is a comprehensive dental benefit. The Basic Plan Dental provides preventive services only.

A. ELIGIBILITY

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.

<u>Preventive Services</u>

1. 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.

2. Oral examinations (evaluations), twice in any benefit period.

3. Problem focused exams, twice in any benefit period.

4. Dental prophylaxis (cleaning, scaling, and polishing including periodontal maintenance visits), twice in any benefit period.

5. Topical fluoride application for dependent children under age 19, twice in any benefit period.

6. Emergency palliative treatment

7. X-rays as required or in conjunction with the diagnosis of a specific condition.

8. Periapical x-rays as required.

9. Bitewing x-rays twice per benefit period.

10. Full-mouth x-rays once in any 36-month period.

11. 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.

12. 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.

<u>Basic Dental Services</u>

1. General anesthesia in conjunction with covered surgical procedures.

2. Oral surgery and extractions, including pre-operative and post-operative care.

3. Endodontic services: procedures for treatment of teeth with diseased or damaged nerves, including root canals.

4. Periodontic services: 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 planning are limited to once per 24 months.

5. Minor restorative care: 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).

<u>Major Dental Services</u>

1. Prosthodontic services: Services and appliances that replace missing natural teeth; includes fixed bridgework, partial dentures, and complete dentures.

2. Implants: Covered; 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.

3. 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.

4. Occlusal guards, for bruxism only, limited to once in 5 years.

5. Consultations, as required.

Orthodontic Services

1. Services, treatment, and procedures required for the correction of malposed teeth.

2. 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

CDT CODE	DESCRIPTION
D00274	Bitewings – four radiographic images
D00277	Vertical bitewings 7 – 8 radiographic images
D00290	Posterior – anterior or lateral skull and facial bone survey radiograph image
D00330	Panoramic radiographic image
D01110	Prophylaxis – adult
D01120	Prophylaxis – child
D01206	Topical application of fluoride varnish
D01208	Topical application of fluoride – excluding varnish
D04910	Periodontal maintenance

Special Accident Benefit

The Plan provides extra coverage for dental treatment of accidental injuries to teeth or restorations. These services are covered only with Prior Authorization, except for Emergency services. 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 Individual may be entitled to or receives benefits under any applicable Workers' Compensation Act, Occupational Disease policy or similar law (including settlement of a claim).

3. Any service or supply not performed or furnished by a Dentist, except X-rays ordered by a Dentist and services by a licensed dental hygienist under the Dentist's supervision.

4. Services or supplies performed for cosmetic purposes or to correct congenital malformations.

5. Charges not reasonably necessary or customarily provided for the Covered 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.

D-VII. VISION

The Vision Benefit is self-funded by the Plan. The Plan has contracted with the Network Sponsor to process claims in the Vision Benefit, to make Prior Authorization determinations, and for access to a vision Network. Vision 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.

Premium Vision Plan is a comprehensive vision benefit. The Basic Vision Plan provides access to discounted services only.

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 Medicare Advantage plan.

3. For certain **Apprentice** eligibility classes, the Basic Vision Plan is provided to Participants and Dependents.

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 herein; 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 to the Network Provider. 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 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 the Network Sponsor 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 as may be covered under 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 Individual has fully complied with the reimbursement or subrogation provisions of this Plan.

10. Any vision services to the extent that benefits are payable under the Medical Benefit of this Plan.

11. Costs for services and supplies in excess of Plan maximum benefits.

E. SPECIAL LOW VISION BENEFIT

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 Network Sponsor for approval of coverage in the low vision program. 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 Network Provider performs the low vision analysis, a $10 Copayment applies, and the remainder is paid in full by the Plan. If a Non-Network 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 the Network Sponsor, regardless of whether furnished by a Network 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.

D-VIII. SHORT-TERM DISABILITY BENEFITS

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 and Participants eligible only for the Basic Plan.

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 in the amount set forth in the Schedule of Benefits.

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-IX. 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. The terms and conditions of such benefits are as stated in the policies, which are adopted and incorporated by reference, and attached here to as Exhibit A. In the event of any inconsistency with the summary provided below and the terms of insurance policy, the insurance policy will control.

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 set forth in the Schedule of Benefits.

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:

1. To the Participant's Surviving Spouse.

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

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

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

5. 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. LIMITATIONS ON THE 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.

F. AD&D EXCLUSIONS

No benefits are payable:

1. For any Participant while covered under COBRA.

2. For any Participant or Dependent covered 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.

D-X. 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 for the safety enhancement benefit, the safety training course known as the “10-Hour OSHA Course.”

Upon completion of the 10-Hour OSHA course, the Plan will provide, without charge, to all active Participants eight (8) Hours of Approved Safety Training per year to satisfy requirements of the Union.

C. SUBSTANCE ABUSE TESTING

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

D-XI. 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.

The Contracted Providers and Claims Fiduciaries are:

- Medical claims and appeals: UMR
- Dental claims and appeals: Delta Dental
- Vision claims and appeals: VSP
- Short-term disability: Board of Trustees

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.		
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%

COMPREHENSIVE MEDICAL BENEFITS			
	Network Provider		**Non-Network Provider**
• 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.		
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			

DENTAL BENEFITS			
	PPO Network	**Premier Network**	**Non-Network**
• 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 page 61 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	
Weekly Indemnity	$300 per week
Maximum Benefit	26 weeks

D-XIII. 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.

The Contracted Providers and Claims Fiduciaries are:

- Medical claims and appeals: UMR
- Dental claims and appeals: Delta Dental

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 Deductible does not apply	70%	Not covered

COMPREHENSIVE MEDICAL BENEFITS		
	Network Provider	**Non-Network Provider**
	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

D-XV. SCHEDULE OF BENEFITS – PRESCRIPTION DRUGS

This Schedule of Benefits applies to Covered Persons in the Premier 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.

The Contracted Provider and Claims Fiduciary: Express Scripts, Inc. and Accredo Specialty Pharmacy

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.			

D-XVII. SCHEDULE OF BENEFITS – LIFE AND AD&D

This Schedule of Benefits applies to Covered Persons in the Premier 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.

The Contracted Provider and Claims Fiduciary: MetLife

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	
Life Insurance	**Benefit**
• Participant	$8,000
• Dependent	$2,000
AD&D	
• 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

D-XIX. 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

D-XXI. 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

EXHIBIT A – LIFE AND AD&D POLICY

RESOLUTION AMENDING THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND PLAN
DOCUMENT

The following reflects action taken by the Board of Trustees (the "Trustees") of the Mid-America Carpenters Regional Council Health Fund (the "Fund") on November 19, 2025:

WHEREAS, Article XVIII section 18.01(A) of the Mid-America Carpenters Regional Council Health Fund Plan Document (the "Plan") permits the Trustees from time to time to amend the terms of the Plan;

WHEREAS, the Trustees desire to amend the Plan as follows:

- To revise the maternity leave benefit to be used 13 weeks prior to delivery and 13 weeks after delivery.
- To reflect the new Life Insurance carrier, MetLife, and to revise the Life and Accidental Death & Dismemberment benefits accordingly.
- To align the special enrollment provisions for newly acquired dependents between the Northern Region and Southern Region Benefit Plans.
- To clarify the eligibility provisions for dependent stepchildren.
- To add a disability extension provision for Non-Bargained In-House Employees to the Southern Region Benefit Plan.
- To eliminate the option for certain retirees to elect separate medical and prescription drug benefits.

NOW, THEREFORE, BE IT RESOLVED, that the undersigned hereby execute this Resolution to reflect that the Trustees at their November 19, 2025 meeting resolved to amend the Plan by adopting Amendment No. 17, as set forth as Exhibit A attached hereto, effective as of the dates provided therein.

Gary Perinar, Chairman — 11/19/2025 Date

Gerald W. Thiel, Jr., Secretary — 11/19/2025 Date

EXHIBIT A

AMENDMENT NO. 17
TO THE
MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
PLAN DOCUMENT

The Mid-America Carpenters Regional Council Health Fund Plan Document is hereby amended as follows:

1. Effective August 1, 2025, Article III, "Eligibility," Section 3.03(A)(1), is amended to read as follows:

> Is receiving pension benefits from the Mid-America Carpenters Regional Council Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Fund") or the Mid-America Carpenters Regional Council Millmen Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Fund") based on at least ten (10) years of Eligibility Service. If at some time the Participant did not earn Eligibility Service for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of Eligibility Service. For purposes of accumulating the necessary ten (10) or fifteen (15) years of Eligibility Service, years of service with a Specialty Shop can be combined with Eligibility Service.

2. Effective January 1, 2026, Article III, "Eligibility," Section 3.04(A) is amended to read as follows:

> (A) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A), Paragraphs 1 thru 5, and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are not Medicare eligible are eligible to enroll in the following coverage options:
>
> (1) The prescription drug benefit, as described in Article VIII and Appendix B, except Deferred Lathers are not eligible for the prescription drug benefit; and comprehensive medical benefits as described in Article VII and Appendix B; and/or
>
> (2) Dental benefits as described in Article VII and Appendix B; and/or
>
> (3) Vision benefits as described in Article VI and Appendix B.
>
> Will County Local 174 Carpenters Welfare Fund retirees who retired on December 1, 2018 or earlier must elect and maintain both the prescription drug and comprehensive medical benefits under this Plan Section 3.04(A)(1) and (2), but have the option of separately electing dental or vision benefits.
>
> Dependents who are not eligible for Medicare may only enroll in the coverage options that the Retiree is enrolled in. Dependents who are eligible for Medicare may only enroll in the dental and/or vision benefits that the Retiree is enrolled in and/or the MAPD Benefit.

3. Effective September 1, 2025, Article III, "Eligibility," Section 3.05(C)(2) is amended to read as follows:

> (2) Exception for Newborns, Adopted Children and Children Placed for Adoption: Provided that the Retiree elected coverage, in order to enroll a newborn child, adopted child or child placed for adoption, the Retiree must request the required enrollment form(s) from the Fund Office. The completed enrollment form(s) along with the required supporting documentation, as described in Plan Section 3.16(G) for the Active Plan of Benefits, shall also apply to the Retiree Plan. The enrollment form(s) and documentation must be received in the Fund Office within ninety (90) days of the birth, adoption or placement for adoption of the child. Eligibility will commence in accordance with Plan Section 3.06(E). If the required documentation is not received within this ninety (90) day period, coverage shall be terminated. Upon receipt of all required documentation, coverage will be reinstated effective as of the date the Fund Office received all required documents.

4. Effective August 1, 2025, Article III, "Eligibility," Section 3.07(A)(5) is amended to read as follows:

> Each Covered Individual will have their premiums determined on a tiered basis, with premium amounts determined by the years of Eligibility Service that a Participant earned with the Mid-America Carpenters Regional Council Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Pension Fund"); Mid-America Carpenters Regional Council of Carpenters Millmen Pension Fund (prior to January 1, 2022, the "Chicago Regional Council of Carpenters Millmen Pension Fund"); or the Carpenters Pension Fund of Illinois; or by the years of Eligibility Service as determined in accordance with Plan Section 3.03(A)(5) under the Will County Local 174 Carpenters Pension Fund. Surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) will have the same premium rate tier as the deceased Participant. Except as provided in 3.07(A)(6), a Covered Individual must have at least ten (10) years of Eligibility Service to qualify for the premium rate tiers. A Covered Individual who is eligible for Retiree Coverage but who accumulates less than ten (10) years of Eligibility Service is not eligible for the premium rate tiers and must pay the full cost of coverage.

5. Effective September 1, 2025, Article III, "Eligibility," Section 3.16(G)(2), is amended to read as follows:

> (2) Exception for Newborns, Adopted Children and Children Placed for Adoption: Within ninety (90) days of the birth, adoption or placement for adoption of the child, the Participant must submit proof of Dependent status, as described in Plan Section 3.16(G)(1). If timely proof of Dependent status is not received within this ninety (90) day period, coverage shall be terminated. Upon receipt of all required documentation, coverage will be reinstated effective as of the date the Fund Office received all required documents;

6. Effective September 1, 2025, Article III, "Eligibility," Section 3.17(G), is amended to read as follows:

(G) Coverage for a newborn child will be terminated ninety (90) days after the date of the child's birth if an original county certified birth certificate is not received;

7. Effective August 1, 2025, Article III, "Eligibility," Section 3.17(H), is amended to read as follows:

(H) Coverage of a Dependent stepchild terminates on the last day of the month in which the Participant divorces or legally separates from the stepchild's parent or the stepchild's parent dies;

8. Effective September 1, 2025, Article III, "Eligibility," Section 3.23(B), is amended to read as follows:

(B) If an Employee acquires a new Dependent child through birth, adoption or placement for adoption, the Employee shall enroll such Dependent child no later than ninety (90) days after the date of birth or date of adoption or placement for adoption, of the child in accordance with Plan Section 3.16(G). If timely proof of Dependent status is received by the Fund Office, coverage is retroactively granted to the date the new Dependent is acquired. If timely proof of Dependent status is not received within this ninety (90) day period, coverage shall be terminated. Upon receipt of all required documentation, coverage will be reinstated effective as of the date the Fund Office received all required documents.

9. Effective July 1, 2025, Article X, "Short Term Disability Benefits," Section 10.07, "Maternity Leave Benefits," is amended to read as follows:

(A) Eligibility: Pregnant Employees are eligible for Maternity Leave Benefits. Non-bargained Employees, Employees covered by the Low-Cost Medical Plan, former Employees on Continuation Coverage, and Retirees are not eligible for Maternity Leave Benefits.

For purposes of this Section 10.07, "Non-bargained Employees" means an employee for whom an Employer is obligated to contribute to the Health Fund pursuant to a Participation Agreement or other written agreement.

(B) Maximum Period: The Employee 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. Contribution hours do not include HRA contributions.

(C) Benefits are available for no more than twenty-six (26) consecutive weeks, beginning no earlier than thirteen (13) weeks before the expected due date, except for early delivery. The Fund must receive the required application forms completed in full by the Employee and the Employee's attending Physician prior to the commencement of benefits.

(D) Maternity Leave Benefits are in lieu of Non-Occupational Short Term Disability Benefits. An Employee receiving Maternity Leave Benefits is

not eligible to receive Non-Occupational Short Term Disability Benefits for the same pregnancy.

(E) Tax Withholdings: The Plan will follow Federal and State tax withholding rules when paying an Employee's weekly payment.

10. Effective August 1, 2025, Article XI, "Life Insurance Benefits," Section 11.03, "Life Insurance Benefit under the Retiree Plan," is amended to read as follows:

(A) A Retiree or surviving spouse who is enrolled in Comprehensive Medical benefits or the MAPD Benefit and dies prior to attaining age sixty-five (65) is eligible for a Life Insurance Benefit as determined by the Trustees from time to time and as provided in the Schedule of Benefits for the Retiree Plan, see Appendix B. In the event of the death of the Retiree or surviving spouse prior to their attaining age sixty-five (65), the Life Insurance Benefit will be payable in a lump sum to the beneficiary designated by the Retiree or surviving spouse or to the beneficiary determined pursuant to Plan Section 11.04(C)(3).

(B) A Retiree's or surviving spouse's Dependent(s), regardless of age, who are covered under the Plan will also be eligible for a Life Insurance Benefit as provided in the Schedule of Benefits for the Retiree Plan (Appendix B) provided the Retiree is under age sixty-five (65). In the event of a Retiree or surviving spouse Dependent's death prior to the Retiree attaining age sixty-five (65), the Life Insurance Benefit will be payable in a lump sum to their designated beneficiary or the beneficiary determined pursuant to Plan Section 11.04(C)(3).

(C) All insured Life Insurance Benefits shall exclusively be considered for payment pursuant to insurance policy maintained by the Plan. The Plan shall not be responsible for paying insured Life Insurance Benefits in the event it is determined that Benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article XI and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

11. Effective August 1, 2025, Article XI, "Life Insurance Benefits," Section 11.04(C)(3)(a), is amended to read as follows:

(3) If no designated beneficiary survives the Covered Individual or if no beneficiary has been designated, payment will be made consistent with the terms of the life insurance policy in effect at the time of death. The terms of the life insurance policy provide that payment will be made in the following order:

(a) The Covered Individual's surviving spouse/Domestic Partner;

(b) If no spouse/Domestic Partner survives the Covered Individual, in equal shares to the Covered Individual's surviving biological or adopted children;

(c) If no spouse/Domestic Partner or children survive the Covered Individual, in equal shares to the Covered Individual's surviving parents, or to the surviving parent;

(d) If no spouse/Domestic Partner, children or parents survive the Covered Individual, in equal shares to the Covered Individual's surviving brothers and sisters;

(e) If no spouse/Domestic Partner, children, parents or siblings survive the Covered Individual, to the Covered Individual's estate.

12. Effective August 1, 2025, Article XI, "Life Insurance Benefits," Section 11.05, is restated in its entirety to read as follows:

Section 11.05 Accelerated Death Benefit

The Active Plan and Retiree Plan allows for an Employee, Retiree, surviving spouse and their covered Dependents to receive an accelerated death benefit which is a partial payment of the Life Insurance benefit in a lump sum when the Covered Individual is diagnosed with a terminal Illness and not expected to survive more than twenty-four (24) months. The following conditions apply:

(A) The required forms must be completed by the Covered Individual (or their guardian, for Dependent children) and their attending Physician.

(B) The amount of Life Insurance covering the Covered Individual will be reduced by the amount of the Accelerated Death Benefit payment.

(C) For Employees covered under the Active Plan the lump sum cannot be more than eighty (80%) of the Life Insurance Benefit, not to exceed $40,000. For Retirees and covered Dependents, the lump sum cannot be more than eighty (80%) of the Life Insurance Benefit, not to exceed $2,000.

(D) The Accelerated Death Benefit payment is exempt from any legal or equitable process for the Employee's debts.

13. Effective August 1, 2025, Article XI, "Life Insurance Benefits," Section 11.06, is restated in its entirety to read as follows:

Section 11.06 Accelerated Death Benefit for Low Cost Medical Plan Participants

Accelerated death benefits does not apply to the Low Cost Medical Plan.

14. Effective August, 1, 2025, Article XI, "Life Insurance Benefits," the first paragraph of Section 11.07, is amended to read as follows:

If an Employee who is eligible for benefits under the Active Plan of Benefits becomes totally and permanently Disabled while eligible for Life Insurance Benefits, but before the Employee reaches age sixty (60), the Fund will continue the Employee's Life Insurance Benefit by paying the Insurance Company the required premium until the

earliest of the following to occur: the Employee is no longer totally and permanently disabled, the Employee attains age 65, the Employee fails to provide the Insurance Company any required proof of disability, or the Employee fails to be examined by the Insurance Company's physician (if required). Initial proof of disability must be provided to the Fund Office within twelve (12) months after the Employee loses eligibility under the Fund.

For certain Employees who the Fund determines are totally and permanently disabled and who, due to a change in Life Insurance Companies, are no longer covered under either Insurance Company group policy, the Fund may self-fund the benefit.

15. Effective August 1, 2025, the title of Section 11.09 of Article XI, "Life Insurance Benefits," is amended to read as follows:

Section 11.09 Life Insurance Benefits for a Dependent of an Employee, Retiree or Surviving Spouse

16. Effective August 1, 2025, a new section 11.14 is added to Article XI, "Life Insurance Benefits," to read as follows:

Section 11.14 Definitions

For purposes of this Article XI only, the following definitions apply:

(A) A "Dependent" shall include a Domestic Partner who is eligible for and covered under the Plan.

(B) A "Domestic Partner" means an Employee's or Retiree's domestic partner, civil union partner or reciprocal beneficiary who is registered with a government agency where such registration is available.

17. Effective July 1, 2025, the Short-Term Disability Benefits schedule of Appendix A, Schedule of Benefits for the Active Plan of Benefits, is revised to read as follows:

SHORT TERM DISABILITY BENEFITS (For Employees Only)	
Non-Occupational Short Term Disability Benefits (Not work-related)	Weekly benefits include a payment up to $550 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational Short Term Disability Benefits (Work-related)	Weekly benefits include credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Maternity Leave Benefits	Weekly benefits include a payment of $800 and credit of up to 40 hours for a pregnancy or pregnancy-related condition certified by a Physician beginning no earlier than 13 weeks prior to expected delivery date (unless early delivery). Not to exceed a maximum of 26 weeks.

18. Effective August 1, 2025, the Life Insurance Benefits schedule of Appendix A, Schedule of Benefits for Active Plan of Benefits, is revised to read as follows:

LIFE INSURANCE BENEFITS

Contracted Provider: MetLife			
	Eligible Participant	**Spouse/Domestic Partner**	**Child**
Policy amount	$50,000	$2,500	$2,500

19. Effective August 1, 2025, the Accidental Death and Dismemberment Insurance Benefits schedule of Appendix A, Schedule of Benefits for Active Plan of Benefits, is revised to read as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS FOR ELIGIBLE EMPLOYEES ONLY Contracted Provider: MetLife	
Type of Loss	**Benefit Amount**
Loss of life; any combination of hand, foot or sight of one eye; speech and hearing; paralysis of both arms and both legs; or brain damage	100% of the Full Amount*
Loss of arm; leg; or paralysis of both legs	75% of the Full Amount
Loss of hand; foot; sight in one eye; speech or hearing; paralysis of arm and leg on either side of the body	50% of the Full Amount
Loss of thumb and index finger of same hand; paralysis of one arm or one leg	25% of the Full Amount
Coma	1% of the Full Amount beginning on the 7th day of the coma for the duration of the coma, not to exceed 60 months
Third-degree burn	A percentage of the Full Amount equal to the percentage of body surface suffering the third-degree burns
* Full Amount means the Life Insurance Policy amount	

20. Effective August 1, 2025, Insured Benefits schedule of Appendix B, Schedule of Benefits for the Retiree Plan of Benefits, is revised to read as follows:

INSURED BENEFITS	**CARRIER**
• Dental Benefits	Delta Dental of Illinois
• Vision Benefits	Vision Service Plan of Illinois (VSP)
• Life Insurance Benefit – Retirees and Surviving Spouses Under Age 65 Only o $25,000, Retirees o $2,500, Retiree Dependents or Surviving Spouses	MetLife

21. Effective September 1, 2025, Section D-II, "Eligibility & Enrollment" of Appendix D, Southern Region Benefit Plan, is amended to add a new paragraph to the "Continuing Eligibility – Monthly Eligibility" section on page 14 to read as follows:

> If a Participant loses Monthly Eligibility due to an occupational or non-occupational Total Disability, and was actively covered as a Non-Bargained In-House Employee at the time the disability began for 8 total months out of the last 12 months, the Participant's eligibility will be automatically continued, without premiums, on a month-to-month basis, until the earlier of:
>
> 1. The end of the month in which the Participant's Total Disability ends,

2. The end of the month in which the Participant returns to work,

3. The day immediately preceding the Participant's return to active status in the monthly eligibility classification, or

4. The end of the month that contains the first anniversary of the date of the Participant's Total Disability began.

22. Effective August 1, 2025, number 1 of the "Non-Active Classification Benefits" section on page 16 of Appendix D, Southern Region Benefit Plan, Section D-II, "Eligibility & Enrollment," subsection D, "Eligibility – Non-Active Classification," is revised to read 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.

23. Effective September 1, 2025, the second paragraph of the "Dependent Coverage" section on page 17 of Appendix D, Southern Region Benefit Plan, Section D-II, "Eligibility & Enrollment," subsection D, "Eligibility – Non-Active Classification" is revised to read as follows:

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 under the special enrollment rules (see below).

24. Effective September 1, 2025, the "Initial Dependent Coverage" section of Appendix D, Southern Region Benefit Plan, Section D-II, "Eligibility & Enrollment," subsection E, "Dependent Coverage," is revised to read as follows:

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 90 days after the Dependent becomes eligible, enrollment will be effective as of the eligibility date; otherwise, enrollment will be effective as of the date the Benefit Office receives such application. If a Dependent is temporarily enrolled without all required enrollment documentation and the request for supporting documentation is not fulfilled by the 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.

25. Effective September 1, 2025, the first paragraph of the "Special Enrollment" section of Appendix D, Southern Region Benefit Plan, Section D-II, "Eligibility & Enrollment," subsection E, "Dependent Coverage," is revised to read as follows:

> If a Participant acquires a new spouse and stepchildren through marriage the Participant shall enroll such new Dependents within ninety (90) 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 ninety (90) day period, coverage shall effective as of the date Benefit Office receives the required documentation.

26. Effective August 1, 2025, number 2 of the "Termination of Dependent Eligibility" section on page 24 of Appendix D, Southern Region Benefit Plan, Section D-II, "Eligibility & Enrollment," subsection E, "Dependent Coverage," is revised to read as follows:

> 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. For purposes of a Participant's stepchild, the stepchild no longer meets the requirements of a Dependent if the stepchild's parent no longer meets the definition of Dependent or the stepchild's parent dies.

27. Effective July 1, 2025, Appendix D, Section D-VIII, "Short-Term Disability Benefits," subsection D, "Maternity Leave Benefits," is revised to read as follows:

> 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 thirteen (13) 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.

28. Effective August 1, 2025, subsection A, "Eligibility," of Appendix D, Southern Region Benefit Plan, Section D-IX, "Life Insurance and AD&D Benefits," is restated in its entirety to read as follows:

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 and COBRA Participants.

2. **Non-Active Classification** - The life insurance benefit is available to Participants and surviving spouses in the Non-Active Classification except for Participants, Retired Participants and surviving spouses age 65 and older who are enrolled in the Medicare Advantage Program. Certain re-instated non-active Participants are not eligible for life insurance in this section.

   A Retiree's or surviving spouse's Dependent(s), regardless of age, who are covered under the Plan will also be eligible for a Life Insurance Benefit as provided in the Schedule of Benefits for the Non-Active Classification provided the Retiree is under age sixty-five (65). In the event of a Retiree or surviving spouse Dependent's death prior to the Retiree attaining age sixty-five (65), the Life Insurance Benefit will be payable in a lump sum to their designated beneficiary or the beneficiary determined pursuant to section C, below.

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

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

29. Effective August 1, 2025, the third paragraph of subsection C, "Designated Beneficiary," on page 71 of Appendix D, Southern Region Benefit Plan, Section D-IX, "Life Insurance and AD&D Benefits," is revised to read as follows:

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:

1. To the Participant's Surviving Spouse/Domestic Partner.

2. If there is no Surviving Spouse/Domestic Partner, to the Participant's/Surviving Spouse's surviving child or children, equally.

3. If there are no surviving children, to the Participant's/Surviving Spouse's surviving parents, equally.

4. If there are no surviving parents, to the Participant's/Surviving Spouse's siblings, equally.

5. If there are no surviving siblings, to the Participant's/Surviving Spouse's estate.

30. Effective August 1, 2025, Subsection (D), "Extended Life Insurance," of Appendix D, Southern Region Benefit Plan, Section D-IX, "Life Insurance and AD&D Benefits," is restated in its entirety to read as follows:

> If a Participant becomes Totally Disabled before age 60 while eligible for Life Insurance Benefits, the Fund will continue the Participant's Life Insurance Benefit by paying the Insurance Company the required premium until the earliest of the following to occur: the Participant is no longer Totally Disabled, the Participant attains age 65, the Participant fails to provide the Insurance Company any required proof of disability, or the Participant fails to be examined by the Insurance Company's physician (if required).
>
> If a Participant becomes Totally Disabled before age 60 while eligible for Life insurance benefits, the Fund will continue the Participant's Life Insurance Benefit by paying the Insurance Company the required premium until the earliest of the following to occur: the Participant is no longer Totally Disabled, the Participant attains age 65, the Participant fails to provide the Insurance Company any required proof of disability, or the Participant fails to be examined by the Insurance Company's physician (if required).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.
>
> 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.

31. Effective August 1, 2025, Appendix D, Southern Region Benefit Plan, Section D-IX, "Life Insurance and AD&D Benefits," is revised to add a new subsection G to read as follows:

> **G. Definitions.**
>
> For purposes of this Section D-IX only, the following definitions apply:
>
> 1. A "Dependent" shall include a Domestic Partner who is eligible for and covered under the Plan.
>
> 2. A "Domestic Partner" means a Participant's domestic partner, civil union partner or reciprocal beneficiary who is registered with a government agency where such registration is available.

32. Effective August 1, 2025, Appendix D, Southern Region Benefit Plan, Section D-XVII, "Schedule of Benefits – Life and AD&D" is revised to read as follows:

This Schedule of Benefits applies to Covered Persons in the Premier 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. **The Contracted Provider and Claims Fiduciary**: MetLife

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Life Insurance Benefit – Active Classification and Non-Active Classification except for Retirees and Surviving Spouses Over Age 65	**Benefit**
Participant or Retiree	$25,000
Dependents or Surviving Spouse	$2,500
AD&D Benefit – Active Classification Only	
• Loss of life; any combination of hand, foot or sight of one eye; speech and hearing; paralysis of both arms and both legs; or brain damage	100% of the Full Amount*
• Loss of arm; leg; or paralysis of both legs	75% of the Full Amount
• Loss of hand; foot; sight in one eye; speech or hearing; paralysis of arm and leg on either side of the body	50% of the Full Amount
• Loss of thumb and index finger of same hand; paralysis of one arm or one leg	25% of the Full Amount
• Coma	1% of the Full Amount beginning on the 7th day of the coma for the duration of the coma, not to exceed 60 months
• Third-degree burn	A percentage of the Full Amount equal to the percentage of body surface suffering the third-degree burns
* Full Amount means the Life Insurance Benefit amount	