NAVIGATION TIPS

1. Use Ctrl+F (PC) or Cmd+F (Mac) on your keyboard to search for any word in this document.

2. After clicking a link that jumps to another location in this document, hit Alt+Left Arrow (PC) or Cmd+Left Arrow (Mac) on your keyboard to return to the original page.
This chart shows phone numbers, websites and select email addresses for the providers and administrators of the St. Louis Carpenters’ Health and Welfare Trust Fund programs. Please refer also to your member ID card for important contact information.

<table>
<thead>
<tr>
<th>Program</th>
<th>Contact/Provider</th>
<th>Telephone/Website/ Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>General benefits questions</td>
<td>Carpenters’ Benefit Office</td>
<td>314-644-4802 or toll free 877-232-3863</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.carpdc.org/BenefitServices">www.carpdc.org/BenefitServices</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:benefits@carpdc.org">benefits@carpdc.org</a></td>
</tr>
<tr>
<td>Find network medical providers</td>
<td>Coventry Health Care</td>
<td>888-381-8513</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.carpdc.coventryhealthcare.com">www.carpdc.coventryhealthcare.com</a></td>
</tr>
<tr>
<td>Medical pre-certification</td>
<td>Coventry Health Care</td>
<td>800-546-4603</td>
</tr>
<tr>
<td>Member Assistance Program (MAP)</td>
<td>Mercy Member Assistance Program</td>
<td>314-729-4600, press 2 or 800-413-8008, press 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.mbh-eap.com">www.mbh-eap.com</a></td>
</tr>
<tr>
<td>Prescription drugs and home delivery network</td>
<td>Express Scripts, Inc. (ESI)</td>
<td>800-939-2134</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
</tr>
<tr>
<td>Specialty pharmacy</td>
<td>Diplomat Pharmacy</td>
<td>866-748-4768</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://diplomat.is/">http://diplomat.is/</a></td>
</tr>
<tr>
<td>Dental care</td>
<td>Delta Dental of Missouri</td>
<td>314-656-3001 or 800-335-8266</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.deltaentalmo.com/carpdc">www.deltaentalmo.com/carpdc</a></td>
</tr>
<tr>
<td>Vision care</td>
<td>VSP</td>
<td>800-877-7195</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>Weekly Accident and Sickness</td>
<td>Carpenters’ Benefit Office</td>
<td>314-644-4802 or toll free 877-232-3863</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.carpdc.org/BenefitServices">www.carpdc.org/BenefitServices</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:benefits@carpdc.org">benefits@carpdc.org</a></td>
</tr>
<tr>
<td>Life Insurance/AD&amp;D</td>
<td>MetLife</td>
<td>800-458-2479</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.metlife.com">www.metlife.com</a></td>
</tr>
<tr>
<td>Continuation coverage under COBRA</td>
<td>Carpenters’ Benefit Office</td>
<td>314-644-4802 or toll free 877-232-3863</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.carpdc.org/BenefitServices">www.carpdc.org/BenefitServices</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:benefits@carpdc.org">benefits@carpdc.org</a></td>
</tr>
<tr>
<td>Orthopedic “Same Day Appointment” Pledge</td>
<td>Signature Medical Group</td>
<td>314-973-4585 or after normal business hours,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OrthoNow 314-983-4750</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After hours appointment line 314-913-4202</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.signaturemedicalgroup.com">www.signaturemedicalgroup.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:gherrmann@signaturehealth.net">gherrmann@signaturehealth.net</a></td>
</tr>
</tbody>
</table>
# Table of Contents

## Introduction ............................................. 1

## Eligibility and Enrollment ............................. 2
- Eligible Employees .................................... 2
- Initial Enrollment and Change in Circumstances ......... 3
- Active Classification: Eligibility Classes and Initial Eligibility ............................................. 3
  - Continuing Eligibility: Active Members ............. 4
  - Extension for Disability ................................ 4
  - Special Participation Eligibility .................... 4
- Termination of Active Eligibility ....................... 5
- Reinstatement Provisions for Active Members ........ 5
- Self-Payment Provisions – Active Members .......... 5
  - Minimum/Difference Self-Payments ................. 6
- Non-Active Classification and Benefits ................. 7
  - Self Payment Provisions ............................. 8
  - UHC Group Medicare Advantage Program ............. 8
  - Retired Members ................................... 9
  - Retired Self-Employed Members and Non-Pension Members ............................................. 10
  - Disabled Members ................................ 10
  - Union Affiliation of Non-Active Members ........... 10
  - Surviving Spouse .................................. 10
  - Working in the Non-Active Classification .......... 11
  - Termination of Non-Active Eligibility ............... 11
  - Non-Active Eligibility After a Gap in Coverage (Reinstatement) ............................................. 12

## Dependent Coverage ..................................... 12
- Initial Dependent Coverage ............................. 12
- Spousal Eligibility .................................... 12
- Dependent Child Eligibility ............................ 14
- Opting Out of Dependent Coverage ..................... 14
- Termination of Dependent Eligibility ................. 14
- When Coverage Ends ................................... 14

## The Medical Benefit ..................................... 15
- Levels of Benefits .................................... 15
- Platinum Schedule of Benefits ........................ 15
- Gold Schedule of Benefits ............................. 15
- Network Providers ................................... 15
- Determination of Benefit Amounts ..................... 16
  - Allowable Amount .................................. 16
  - Reasonable and Customary Limit .................... 16
  - Deductibles ....................................... 17
  - Copayments ....................................... 17
  - Coinsurance ....................................... 17
  - Out-of-Pocket Maximum ............................. 17
  - Specific Plan Limits ................................ 18
  - Benefit Payable .................................... 18
- Schedule of Medical Benefits ......................... 19
- What’s Covered Under the Plan ......................... 21
  - Non-Preventive Services and Supplies ............... 21
  - Preventive Services and Supplies .................... 29
- General Medical Exclusions and Limitations ........ 31
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization Requirements</td>
<td>34</td>
</tr>
<tr>
<td>Services and Supplies Requiring Prior Authorization</td>
<td>34</td>
</tr>
<tr>
<td>Prior Authorization Procedures</td>
<td>35</td>
</tr>
<tr>
<td>Failure to Obtain Required Prior Authorization</td>
<td>35</td>
</tr>
<tr>
<td>Medical Care Management</td>
<td>35</td>
</tr>
<tr>
<td>High-Risk Pregnancy Care</td>
<td>35</td>
</tr>
<tr>
<td>High-Risk Case Management</td>
<td>35</td>
</tr>
<tr>
<td>The Prescription Drug Benefit</td>
<td>36</td>
</tr>
<tr>
<td>Covered Drugs</td>
<td>37</td>
</tr>
<tr>
<td>Preventive Medications</td>
<td>38</td>
</tr>
<tr>
<td>Special Coverage Limitations</td>
<td>39</td>
</tr>
<tr>
<td>Step Therapy</td>
<td>39</td>
</tr>
<tr>
<td>Supply and Dosage Limit Program</td>
<td>39</td>
</tr>
<tr>
<td>Drug-Specific Limitations</td>
<td>40</td>
</tr>
<tr>
<td>Excluded Drugs</td>
<td>41</td>
</tr>
<tr>
<td>Network Providers</td>
<td>42</td>
</tr>
<tr>
<td>Retail Pharmacy Network</td>
<td>42</td>
</tr>
<tr>
<td>Home Delivery Network (Mail Order)</td>
<td>42</td>
</tr>
<tr>
<td>Specialty Drug Network</td>
<td>43</td>
</tr>
<tr>
<td>Prior Authorization Requirements</td>
<td>43</td>
</tr>
<tr>
<td>Amount of Benefit</td>
<td>44</td>
</tr>
<tr>
<td>The Dental Benefit</td>
<td>45</td>
</tr>
<tr>
<td>Eligibility</td>
<td>45</td>
</tr>
<tr>
<td>Covered Services</td>
<td>45</td>
</tr>
<tr>
<td>Levels of Benefits</td>
<td>46</td>
</tr>
<tr>
<td>Special Accident Benefit</td>
<td>47</td>
</tr>
<tr>
<td>Determination of Benefit Amounts</td>
<td>47</td>
</tr>
<tr>
<td>Coverage Examples</td>
<td>48</td>
</tr>
<tr>
<td>Prior Authorization and Predetermination of Benefits</td>
<td>50</td>
</tr>
<tr>
<td>Limitations and Exclusions</td>
<td>50</td>
</tr>
<tr>
<td>Claims for Dental Benefits</td>
<td>52</td>
</tr>
<tr>
<td>Eligibility</td>
<td>53</td>
</tr>
<tr>
<td>Levels of Benefits</td>
<td>53</td>
</tr>
<tr>
<td>The Vision Benefit</td>
<td>53</td>
</tr>
<tr>
<td>Covered Services and Supplies</td>
<td>54</td>
</tr>
<tr>
<td>Routine Eye Examination</td>
<td>54</td>
</tr>
<tr>
<td>Lenses and Frames</td>
<td>55</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>55</td>
</tr>
<tr>
<td>Additional Discounts</td>
<td>55</td>
</tr>
<tr>
<td>Determination of Benefit Amounts</td>
<td>56</td>
</tr>
<tr>
<td>General Exclusions</td>
<td>56</td>
</tr>
<tr>
<td>Special Low Vision Benefit</td>
<td>56</td>
</tr>
<tr>
<td>Claims for Vision Benefits</td>
<td>56</td>
</tr>
<tr>
<td>The Weekly Accident and Sickness Benefit</td>
<td>57</td>
</tr>
<tr>
<td>Eligibility</td>
<td>57</td>
</tr>
<tr>
<td>Benefits Payable</td>
<td>57</td>
</tr>
<tr>
<td>Exclusions</td>
<td>57</td>
</tr>
</tbody>
</table>
### Third Party Liability – Subrogation and Reimbursement

- Subrogation .......................... 80
- Reimbursement Obligation .......... 81
- Duty to Cooperate with the Plan .... 82
- Right of Offset and Recovery ....... 82

### Important Legal Information

- Notice of Privacy Practices – HIPAA Information .......................... 83
  - Introduction .......................... 83
  - Use or Disclosure of PHI without Your Permission ....................... 83
  - Other Purposes for Which Your PHI May Be Used or Disclosed Without Your Permission .......... 84
  - Use or Disclosure of PHI Requiring Your Permission ..................... 84
  - Your Rights Regarding Your Own PHI ..................................... 84
  - Breach of PHI ................................ 86
  - Plan’s Right to Change Privacy Practices ................................ 86
  - Medicare Part D Disclosure – Medicare Modernization Act (MMA) ........ 86
  - Need Help? ................................ 86
  - A Final Reminder ......................... 86

- Women’s Health and Cancer Rights Act of 1998 ............................ 87
- The Newborns’ and Mothers’ Health Protection Act of 1996 ............... 87
- Continued Coverage Under the Federal Family and Medical Leave Act .... 87
- Continued Coverage During a Military Leave of Absence .................. 87

### Administrative Plan Information

- Rescission ............................. 90
- Discretionary Authority ............... 90
- Plan Amendment and Plan Termination .................................. 91
- Furnishing Required Information and Documentation .................... 91
- ERISA Rights ........................... 91
  - Receive Information About Your Plan and Benefits ....................... 91
  - Continue Group Health Plan Coverage .................................. 92
  - Prudent Actions by Plan Fiduciaries ..................................... 92
  - Enforce Your Rights .................................................. 92
  - Assistance with Your Questions ....................................... 92

### Glossary

- ............................. 93
A Message from the Trustees

The Trustees of the Carpenters’ Health and Welfare Trust Fund of St. Louis are pleased to provide you with this new Summary Plan Description ( SPD). It describes the Plan’s medical, prescription drug, dental, vision, life insurance and other benefits for active members and their eligible dependents. This SPD supersedes and replaces all previous Plan materials you might have.

The information presented here is important — you should keep this copy handy and refer to it whenever you have a question about your benefits. It has been written in a style and tone that should make it easier for everyone who reads it to understand the benefits presented and how to best use them.

The Trustees want the Plan to continue well into the future, however, Plan benefits are not guaranteed to always be available for you and your family. Events may happen in the future that require the Trustees to change the benefits. If we do make changes to the Plan, you will be informed of those changes as soon as possible.

We all know that health care benefits have become more expensive than ever before and there is a limited supply of money to pay for them. Like your family, the Plan has a budget and we need to spend wisely the limited amount of health care money available to us. By understanding your health care benefits and using them wisely, you will get the most benefits at the least cost to you.

We believe this SPD is a major resource in our drive to educate and guide our participants toward healthier living and quality care. Knowledge is power, and it is the key to making smart, cost-effective decisions when it comes to your benefits.

If after referring to the SPD you still have questions about a particular subject, we encourage you to look for answers on our website, www.carpdc.org.

If you still need help, the Benefit Office is here to help you. Call 314-644-4802 or toll free at 877-232-3863; you can also send an email to benefits@carpdc.org.

Best regards,

The Board of Trustees
Introduction

This document is the Summary Plan Description (SPD) of the Carpenters’ Health and Welfare Trust Fund of St. Louis. It provides a summary of the health and welfare benefit plan (the “Plan”) available to eligible members. Note, however, that it does not include all Plan details, which are included in an official Plan Document. If the terms of this SPD conflict with the terms of the Plan Document, the terms of the Plan Document will govern.

The useful information you will find in this SPD includes:

- Detailed eligibility terms;
- Descriptions of your benefits;
- Important limits and exclusions;
- How to file claims and appeals; and
- Other important administrative and legal information.

We have tried to use everyday language in explaining how your benefits work and the steps you will need to follow to take full advantage of them. From time to time, as you read this document you will encounter certain terms that have specific meanings within the context of the Plan. To help you understand these terms, we have italicized them when they first appear and included them in a Glossary (see page 93). You will also find definitions of certain key words throughout the main text.
Eligibility and Enrollment

The eligibility requirements described in this section determine when you and your family members are covered for benefits under the Carpenters’ Health and Welfare Trust Fund of St. Louis. Please see Life Insurance and Safety Enhancement Benefits on page 58 for additional eligibility requirements for those benefits.

**Eligible Employees**

You may become eligible for benefits as a member of the Plan if you are covered by a collective bargaining agreement requiring contributions to the Carpenters’ Health and Welfare Trust Fund of St. Louis.

You are also eligible to become members of the Plan if:

- You are an employee of:
  - The Carpenters’ District Council of Greater St. Louis and Vicinity;
  - Benefit Plans sponsored by the District Council; or
  - Any other employer obligated by written agreement to make contributions to the Fund on behalf of such employees and accepted by the Trustees.

- You are a retired employee for whom the District Council was the recognized bargaining representative when you were actively working, or were an employee of one of the employers described above.

- You are a member of an eligible Special Participation group, including:
  - Non-bargained office employees of contributing employers, and
  - Other groups of employees for whom contributions are made on a month-to-month basis under agreements acceptable to the Trustees.
Initial Enrollment and Change in Circumstances

All new members, regardless of their employment classification, must complete the Plan’s Enrollment/Change Form before benefits will be paid.

In addition, every member must complete the Enrollment/Change Form upon your marriage, legal separation, divorce, birth or adoption of a child, or if you or a dependent becomes covered under another health plan (medical, prescription, dental, or vision).

The Plan may require documentation to establish proof of eligibility of dependents, such as birth certificates or marriage licenses. The Plan may also require authentic copies of court documents, such as divorce decrees, to determine whether this Plan is the primary payer for a member or dependent.

There are three eligibility classes within the active classification, each with its own terms for initial eligibility, as detailed in the chart below:

<table>
<thead>
<tr>
<th>Eligibility Classification</th>
<th>Initial Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outside Eligibility:</strong> members employed in work covered by a collective bargaining agreement or participation agreement requiring contributions to this Plan for hours (not limited to 133 hours per month)</td>
<td>An employee initially becomes eligible for benefits in the Outside Eligibility class on the first day of the month following the employee’s completion of at least 500 credit hours during the preceding six consecutive months.</td>
</tr>
<tr>
<td><strong>Inside Eligibility:</strong> members employed in work covered by a collective bargaining agreement requiring contributions to this Plan for all hours of work up to a maximum of 133 hours per month</td>
<td>An employee initially becomes eligible for benefits in the Inside Eligibility class on the first day of the month following the employee’s completion of at least 250 credit hours during the preceding six consecutive months.</td>
</tr>
<tr>
<td><strong>Special Participation Eligibility:</strong> members of a special participation group</td>
<td>An employee initially becomes eligible for benefits in the Special Participation Eligibility class on the first day of the month following the month in which the employer first makes a timely contribution on the employee’s behalf.</td>
</tr>
</tbody>
</table>
Continuing Eligibility: Active Members

If you have established Outside or Inside Eligibility, you will continue to be eligible based on benefit quarters that follow contribution quarters. Benefit quarters begin each January 1, April 1, July 1 and October 1, as shown on the following chart:

<table>
<thead>
<tr>
<th>Your hours worked during this CONTRIBUTION QUARTER</th>
<th>Provide coverage eligibility for this BENEFIT QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>August, September, October</td>
<td>January, February, March</td>
</tr>
<tr>
<td>November, December, January</td>
<td>April, May, June</td>
</tr>
<tr>
<td>February, March, April</td>
<td>July, August, September</td>
</tr>
<tr>
<td>May, June, July</td>
<td>October, November, December</td>
</tr>
</tbody>
</table>

The Plan has three separate tests to determine if you qualify for continuing eligibility, applied in this order:

- **Quarterly Rule:** A member who works at least 300 credit hours in a contribution quarter will have eligibility extended through the benefit quarter that next follows that contribution quarter. If you do not qualify under this rule, the next rule is applied.

- **Look-Back Rule:** A member who worked at least 1,200 credit hours during a period of 12 consecutive months, ending with any month in a contribution quarter, will have eligibility extended through the benefit quarter that next follows that contribution quarter. Members can maintain eligibility under this provision only if they remain eligible for covered employment. If they do not qualify under this rule, the next rule is applied.

- **Plan Year Rule (Outside Eligibility only):** A member in the Outside Eligibility class who worked at least 1,300 credit hours in a Plan Year will have eligibility extended until March 31 of the next Plan Year. Members in the Outside Eligibility class can maintain eligibility under this provision only if they remain eligible for covered employment. If you do not qualify under this rule, refer to Self-Payment Provisions — Active Members on page 5.

**Extension for Disability**

Coverage in the Outside or Inside Eligibility class will generally end if you fail to qualify under at least one of the provisions outlined above and do not elect an available self-payment option (see page 8). However, if a member is unable to work sufficient credit hours to maintain eligibility due to an occupational or non-occupational disability, and has worked at least 1,300 credit hours during the 12 consecutive months prior to the beginning of the disability, the member’s eligibility in the Outside or Inside Eligibility class will be automatically continued, without contributions, until the earlier of:

- The date the disability ends, or
- The last day of the benefit quarter containing the first anniversary of the date the disability began.

**Special Participation Eligibility**

The continuing eligibility of a member in the Special Participation Eligibility class is determined on a month-to-month basis. The employer’s payment of the required monthly contribution in one month maintains the member’s eligibility for the following month.
Termination of Active Eligibility

Unless you elect an available self-payment option (see below), your coverage will end on the earliest of the following dates:

- The last day of eligibility earned by your credit hours.
- The date of your death.
- The date you falsify any information in connection with a claim for benefits or commit any action with the intent to defraud the Plan.
- The date the Plan terminates.

Your eligibility for benefits under the Plan will also end on the date you become eligible for Medicare coverage due to age or disability. Your Medicare coverage is primary to this Plan if you are employed by a small employer as defined by Medicare, or if you have had 30 months of Medicare coverage on account of end-stage renal disease (ESRD).

If your eligibility for coverage would otherwise terminate as a result of any of the provisions described above, your eligibility will nevertheless continue to the extent required under the terms and conditions of the Family and Medical Leave Act of 1993 (FMLA) and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are absent from employment by reason of service in the uniformed services, and would otherwise lose coverage on account of such absence, you may elect to continue coverage in the Plan as provided under USERRA.

Reinstatement Provisions for Active Members

Outside and Inside Eligibility Class: If you have lost coverage in the Outside or Inside Eligibility class and are not participating as a self-pay member in the non-active classification (see page 8), you may reinstate active coverage by working the same number credit hours in a contribution quarter required for continuing eligibility, as described above under Continuing Eligibility: Active Members. Note that you must work these credit hours within one year of your termination date for coverage to be reinstated. The reinstated coverage becomes effective on the first day of the next benefit quarter.

If you have lost coverage in the Outside or Inside Eligibility class and do not qualify for reinstated coverage, you must again satisfy the initial eligibility requirements to regain active coverage, as described above under Active Classification: Eligibility Classes and Initial Eligibility.

Special Participation Eligibility Class: If you have lost coverage in the Special Participation Eligibility class, you may reinstate the lost coverage only if your employer makes a timely contribution on your behalf. The employer’s employees must qualify as a Special Participation Group. Your coverage in the Special Participation Eligibility class will be reinstated on the first day of the month following the month in which the Plan receives the employer’s contribution.

Self-Payment Provisions – Active Members

If you who would otherwise lose coverage in the Outside or Inside Eligibility class because of insufficient credit hours, and you are not drawing a Normal, Supplemental, Deferred or Disability Pension under any of the Carpenters’ Pension Plans, you may maintain continuous coverage for a limited time by electing either minimum/difference self-payments, as described below, or COBRA continuation coverage (see page 71). Note that these two options are mutually exclusive — you may select one or the other, but not both. If you elect either option, you may still regain active coverage by working credit Hours, as described above under Reinstatement Provisions for Active Members.

If you would otherwise lose coverage in the Special Participation Eligibility class, you may maintain continuous coverage for a limited time by electing COBRA. (The minimum/difference self-payment option is not available to members in this eligibility class.)
Minimum/Difference Self-Payments

If you are not in the Special Participation Eligibility class and have not earned enough credit hours in a contribution quarter to maintain active eligibility, you may elect to maintain continuous active eligibility by making self-payments directly to the Fund. These are referred to as “minimum/difference payments.” If you make timely payments for a particular benefit quarter, in the required amount, your eligibility will be extended through that benefit quarter.

The required amount of your minimum/difference payment for a benefit quarter is equal to the difference between 300 and the number of credit hours you actually earned in the corresponding contribution quarter, multiplied by the current hourly employer contribution specified in the labor agreement under which most contributions are paid. If you earned no credit hours during the contribution quarter, your required payment amount is equal to the entire employer contribution for the minimum 300 credit hours.

If you choose to maintain your coverage eligibility through the use of minimum/difference payments, your coverage must be continuous — that is, it must begin with the first contribution quarter in which you earned less than 300 credit hours.

You may generally maintain active coverage by minimum/difference payments for no more than eight consecutive benefit quarters (24 months). The exception to this rule is that you may maintain coverage for up to four additional quarters (an additional 12 months) by making minimum/difference payments based on a minimum of 400 credit hours per contribution quarter, rather than 300.

Maintaining your coverage eligibility through the use of minimum/difference payments is an alternative to making a COBRA election (see page 71). COBRA continuation coverage is not available to you if you lose coverage at the end of one or more quarters of minimum/difference payments (such as if you fail to make timely payments).

If you exhaust the maximum permissible period of coverage by making minimum/difference payments, you can regain active coverage only by satisfying the continuation requirements described above under Continuing Eligibility: Active Members, or the reinstatement requirements described above under Reinstatement Provisions for Active Members. Alternatively, you may be able to maintain coverage in the non-active classification (see Non-Active Classification and Benefits on page 7).

If you end a period of coverage maintained by minimum/difference payments, you must have at least two consecutive quarters of active coverage earned solely with credit hours before you will be permitted to begin a new period of coverage maintained by minimum/difference payments.

You have the option to pay a minimum/difference payment for a benefit quarter in one payment for the entire quarter of coverage or in monthly installments. If you choose to pay quarterly, your payment is due on the first day of the month prior to the applicable benefit quarter. It must be received by the Fund within 15 days of the due date to be accepted. The payment schedule for quarterly payments is shown in the following table:

<table>
<thead>
<tr>
<th>BENEFIT QUARTER FOR COVERAGE</th>
<th>PAYMENT DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>January, February, March</td>
<td>December 1</td>
</tr>
<tr>
<td>April, May, June</td>
<td>March 1</td>
</tr>
<tr>
<td>July, August, September</td>
<td>June 1</td>
</tr>
<tr>
<td>October, November, December</td>
<td>September 1</td>
</tr>
</tbody>
</table>

If you choose to pay monthly, the amount due each month is one-third of the total payment due for the benefit quarter. Monthly payments are required to be paid automatically by direct debit or credit card on the first of the month, or the next business day, prior to the applicable month of coverage. If your payment is not received on time, your coverage will terminate at the end of the last month for which timely payment was made.
COBRA Payments

If you are an active member who is otherwise losing coverage (and, in the case of a member in the Outside or Inside Eligibility classes, has not elected minimum/difference payments), you may elect COBRA continuation coverage as described under COBRA Continuation Coverage on page 71.

Non-Active Classification and Benefits

The non-active classification allows qualified members and their dependents to continue coverage under the Plan after they do not qualify under the active classification, by making self-payments. To be eligible in the non-active classification, you must have previously had coverage as an active member in the Outside or Inside Eligibility class (or must be a dependent of such member), within one of the following categories:

- Retired members
- Non-pension members
- Retired self-employed members
- Disabled members
- Surviving spouses

The benefits provided under the non-active classification are the same as those provided under the active classification as long as the required premium is paid, with the following exceptions:

Benefits for Medicare-eligible individuals: If you are covered in the non-active classification as a member or dependent and become eligible for Medicare, you will lose eligibility for any benefit from the Plan. If you enroll in the UHC Medicare Advantage Program immediately upon becoming eligible for Medicare (see UHC Group Medicare Advantage Program on page 8), you will remain eligible for the Plan’s Life and Accidental Death benefit. You will also have the option to remain eligible for the Plan’s Dental benefits at an increased premium. If you are a member and enroll in the UHC Medicare Advantage Program, you will also have the option to maintain family coverage in the non-active classification of this Plan for your dependents by paying the applicable premium.

Weekly Accident and Sickness benefits: If you become disabled while covered in the non-active classification, you are not eligible to receive Weekly Accident and Sickness benefits.

Dental benefits: Members covered in the non-active classification, and members or dependents enrolled in the UHC Medicare Advantage Program, have the option to purchase the Plan’s Dental benefits at an increased premium. You must enroll for optional Dental benefits at the time you first enroll in the non-active classification; otherwise, you must wait for the next Open Enrollment period of October 1 through December 15. If you drop the Dental benefit after initially electing it, you may not elect it again later.

Dependent coverage: Members covered in the non-active classification may elect single coverage (for the member only), or family coverage (for the member and dependents) at a higher premium.

An election of single coverage is irrevocable, except that you may change to family coverage in the following circumstances:

- Upon reinstatement to non-active coverage after a gap in coverage, as described under Non-Active Eligibility After a Gap in Coverage; or
- By applying for family coverage within 30 days after one of your dependents becomes entitled to a special enrollment period as permitted under federal regulations.
**Self Payment Provisions**

To pay for coverage, members and dependents in the non-active classification must pay the required premium directly to the Benefit Office.

Your premium amount is determined based on your coverage selection and your length of service with the Plan. Your premium for coverage under the non-active classification and for individuals participating in the UHC Medicare Advantage Program is due on the first day of the month prior to the month of coverage. If your payment is not received on time, your coverage will terminate at the end of the last month for which timely payment was made.

All premiums under the self-pay provisions are due on the first day of the month prior to the month of coverage, and must be received in the Benefit Office within 15 days of the due date to be accepted.

**UHC Group Medicare Advantage Program**

As stated under Benefits for Medicare-eligible individuals on the page 7, if you become eligible for Medicare while covered as a member or dependent in the non-active classification and you take no further action, you lose eligibility for any benefit from the Plan. To assist your transition to Medicare, the Plan has arranged for UnitedHealthcare to offer the UHC Medicare Advantage Program, at group premium rates and with benefits that may be attractive to you. The UHC Medicare Advantage Program is a group-type insurance program providing Medicare Part C benefits, and is available only to individuals who become eligible for Medicare while covered in the Plan’s active or non-active classification.

If you choose to participate in the UHC Medicare Advantage Program upon first becoming eligible to enroll, you will remain eligible for the Plan’s Life and Accidental Death benefit. You will also retain the right to elect coverage under the Plan’s Dental benefits. In each case, a monthly premium will charged to you.

Benefits under the UHC Medicare Advantage Program are not Plan benefits — they are provided entirely independently of the Plan under an insurance contract with UnitedHealthcare, in return for which a premium is charged to members. The Plan’s role is strictly to collect and remit monthly premiums to UnitedHealthcare on behalf of individuals who choose to participate, and to report to UnitedHealthcare the individuals who have paid such premiums. The Plan’s monthly charge for an individual who participates in the UHC Medicare Advantage Program includes the following:

- 100% of the premium due from the individual to UnitedHealthcare;
- an administrative fee for the Plan’s services;
- the Plan’s own premium for Life and Accidental Death and Dismemberment benefits; and
- the Plan’s own premium for optional Dental benefits, if elected.
The Plan does not endorse the UHC Medicare Advantage Program or require its use, or pay any part of its cost. Participation in the UHC Medicare Advantage Program is strictly voluntary, at the option of an individual who becomes eligible for Medicare while covered in the Plan’s non-active classification. Such an individual retains the right to pursue other options; he or she may instead choose conventional Medicare (Parts A and B), or Medicare plus private supplemental insurance, or a different Medicare Advantage plan. Note, however, that enrollment in a different Medicare Advantage plan or in Medicare Part D will disqualify you for participating in the UHC Medicare Advantage Program.

To be accepted for participation in the UHC Medicare Advantage Program, you must be enrolled in Medicare Parts A and B. You must actively enroll in the UHC Medicare Advantage Program prior to your Medicare effective date or no later than 60 days after first becoming eligible for Medicare. If you wish to maintain optional benefits under the Plan, you must make that election at the same time. Your dependent may participate in the UHC Medicare Advantage Program only if, and so long as:

- You have elected family coverage;
- You were covered in the non-active classification before becoming eligible for Medicare; and
- You enrolled in the UHC Medicare Advantage Program after becoming eligible for Medicare.

Retired Members

For purposes of eligibility for retiree coverage in the non-active classification, a member “retires” when he or she begins to receive pension benefits from any of the following Carpenters’ Pension Plans: St. Louis, Kansas City, Kansas Building Trades, or Geneva.

Eligibility for retiree coverage in the non-active classification of the Plan occurs on one of the following dates, depending on the member’s personal circumstances:

- The date the member retires;
- Or, if later, when the member’s eligibility in the active classification is exhausted; or
- When the member satisfies the requirements described below under Retired Self-Employed Members and Non-Pension Members.

If you retire while covered in the Outside or Inside Eligibility class, you may be eligible for retiree non-active coverage. For an additional premium, you may also cover your eligible dependents (see Dependent Coverage on page 12). To keep coverage without interruption, you must enroll for retiree coverage by the first day after your active coverage ends. If you retire with a Normal, Supplemental, Deferred or Disability Pension while making minimum/difference payments, you may not make any additional minimum/difference payment after your retirement. If you retire while covered by COBRA you may extend the period of active coverage until the end of the applicable COBRA period.

Important Note

Unlike members in the non-active classification, members or dependents who are covered in the active classification and who become eligible for Medicare do not lose eligibility to participate in the Plan. Accordingly, they are not eligible to enroll in the UHC Medicare Advantage Program while continuing in active classification.
Retired Self-Employed Members and Non-Pension Members

**Self-employed members:** If you are a self-employed member and not eligible to receive a pension from the Carpenters’ Pension Plan, you can still qualify for retiree coverage in the Plan in the non-active classification if you meet all of the following conditions:

- You have reached age 62;
- You have stopped working; and
  - You have been covered by the Plan as an active member for the five consecutive years preceding enrollment for retiree coverage.

**Non-pension members:** A non-pension member is an active member in the Outside or Inside Eligibility class, other than a self-employed member, who is not eligible to receive a pension from the Carpenters’ Pension Plan. If you are a non-pension member you can qualify for retiree coverage in this Plan in the non-active classification if you meet all of the following conditions:

- You have permanently stopped working in any employment and you have notified the Plan.
- You were covered in the Outside or Inside Eligibility class immediately before beginning retiree coverage.
- You enroll for retiree coverage by the first day after your active coverage ends; or if earlier, immediately following the day you stopped working.

If you participate in the non-active classification and then terminate that participation for any reason, you have a one-time option to re-enroll in that program if you qualify for all the provisions for non-active eligibility after a gap in coverage.

Disabled Members

If you become totally disabled while covered in the Outside or Inside Eligibility class, you qualify for coverage in the non-active classification during your disability if you meet all of the following conditions:

- You must provide satisfactory medical evidence of total disability. For purposes of this eligibility provision, “total disability” means that the member is prevented, due solely to sickness or injury, from engaging in any of the usual activities of his or her specific, customary occupation.
- You must provide such evidence to the Trustees as soon as reasonably possible after it becomes available to you.
- You must enroll in non-active disability coverage by first day after your active coverage ends.
- You must provide medical evidence of the continuation of total disability as often as requested by the Plan.

Your non-active disability coverage will terminate when you are no longer totally disabled under the terms of the Plan.

Union Affiliation of Non-Active Members

As a condition of eligibility for benefits under the non-active classification, all non-active members (except surviving spouses and retired employees of the District Council or Carpenters’ Benefit Funds), including retired self-employed, non-pension and disabled members, must maintain membership in the District Council or its affiliated Locals at all times to be eligible for non-active coverage.

Surviving Spouse

In the event you die as a member in the active or non-active classification, in any class except Special Participation Eligibility, if your spouse had dependent coverage at the time of your death, your surviving spouse may qualify for surviving spouse coverage in the non-active classification. This coverage will continue for your surviving spouse’s lifetime, except if your surviving spouse remarries; the coverage will terminate upon your surviving spouse’s remarriage. To obtain this coverage, your surviving spouse must enroll no later than 30 days after termination of coverage as your dependent.
Your surviving spouse may elect single coverage or family coverage, at the respective applicable premiums. An election of family coverage provides coverage only for your surviving spouse and those persons who were your dependent children at the time of your death. Your stepchildren are not eligible for benefits under the surviving spouse coverage.

A surviving spouse covered under the Plan in the non-active classification is generally considered to be a member for purposes of the Plan.

**Working in the Non-Active Classification**

Members covered in the non-active classification (other than as disabled, retired self-employed or non-pension members) are not prohibited from earning credit hours in this Plan during non-active coverage. Note, however, that some pension plans do not allow participants to work, or limit the number of hours worked while the participant draws a pension benefit. Members who earn credit hours during non-active coverage will receive a credit against their self-payment on account of the hours worked. Your credit for hours worked in a month is limited to the amount of the premium self-payment due for that benefit month and is paid twice a year from the Benefit Office.

Please note that some pension plans do not allow participants to work, or limit the number of hours worked while the participant draws a pension benefit.

Once you enroll in non-active coverage you may not reestablish active coverage except for a one-time opportunity to reestablish coverage in the Active classification under the following conditions:

- You must provide advance written notice to the Benefit Office of the intent to have credit hours applied to reinstate active eligibility. At that time, employer contributions for you will stop being credited against your premium self-payments and will begin to be credited toward initial active eligibility;
- You must satisfy the requirements for initial Outside or Inside eligibility while maintaining continuous non-active coverage through premium self-payments; and
- Only credit hours earned during non-active coverage as outlined above will be applied to satisfy initial eligibility requirements.

You may move from non-active to active coverage only once, except that if you are a member whose non-active coverage is due to total disability, you are not bound by this limitation when you are no longer totally disabled.

**Termination of Non-Active Eligibility**

As a non-active member, your coverage will end on the earliest of the following dates:

- In case of non-payment at the end of the month for which your last timely payment was received.
- The date of your death.
- The date you falsify any information in connection with a claim for benefits or commit any action with the intent to defraud the Plan.
- The date the Plan terminates.

In addition, your eligibility as a non-active member for all or most benefits in the Plan will end on the date you are eligible for Medicare, as described under Benefits for Medicare-eligible individuals on page 7 and UHC Group Medicare Advantage Program on page 8.
Non-Active Eligibility After a Gap in Coverage (Reinstatement)

If you are a member or a dependent, with active or non-active coverage, and your coverage ends for any reason, you may be reinstated to (or begin) non-active coverage after this break in coverage only if you meet all the following conditions:

- You must have had other comparable medical and prescription drug health coverage that did not terminate more than 63 days before the requested date for beginning or resuming non-active coverage in this Plan;
- You must satisfy all other eligibility requirements for non-active coverage; and
- Your gap in coverage under the Plan is not more than five years, except in the following cases:
  - Your dependent who opted out of coverage in the Plan and thereafter maintained continuous health coverage through the dependent’s own employer, and this coverage did not terminate more than 63 days before the requested date for beginning or resuming non-active coverage in this Plan; or
  - You are a member whose most recent coverage ended in the active classification, and who thereafter has been continuously employed by a contributing employer until a date no more than 63 days before the requested date for beginning non-active coverage in this Plan.

Note that coverage for a surviving spouse must be continuous; it cannot be reinstated after a termination.

If reinstatement of coverage is approved, non-active coverage will be effective the first day of the month following the month in which any required premium is paid. If you begin or resume non-active coverage after a gap in coverage under this Plan, you will not be eligible for Life or Accidental Death and Dismemberment Insurance Benefits (see page 58).

Dependent Coverage

Dependent coverage under the Plan is generally determined by the same rules regardless of whether the member has active or non-active coverage. Your qualified dependents are covered automatically if you are a member in the active classification. If you are a member in the non-active classification, your dependents are covered only if you have elected family coverage at an increased premium. A Medicare-eligible dependent of a non-active member may be covered for limited Plan benefits, at the applicable premium, as described under Benefits for Medicare-eligible individuals on page 7 and UHC Group Medicare Advantage Program on page 8.

Your eligible dependents are your spouse and each of your children up to the age of 26, provided that any additional conditions for eligibility of spouses and children, as set forth below, are met. Only your spouse and children are eligible as dependents; no other relative or other person is eligible, regardless of financial support provided by you.

Initial Dependent Coverage

For all eligibility classes, initial coverage for your dependents is based on your eligibility. Coverage of an existing dependent will begin when your family coverage begins and the dependent is enrolled. If you are an existing member with family coverage, coverage of a new dependent is automatic after proper enrollment is completed.

Spousal Eligibility

For purposes of eligibility in this Plan, your spouse is the individual to whom you are married. The validity of a marriage shall be determined under the law of the state in which the marriage took place.

Your spouse is no longer considered a spouse under the Plan upon divorce, annulment of marriage, or death. Eligibility and coverage of your spouse as a dependent ends on the last day of the month in which a decree of divorce or annulment is entered, or in which the spouse’s death occurs.

Your spouse will lose eligibility under the Plan in the event of divorce, annulment of marriage, or death. Eligibility and coverage of your spouse ends on the last day of the month in which a decree of divorce or annulment is entered, or in which the spouse’s death occurs.
Spousal coverage of active members: If you are a member in the active classification, your spouse will not be eligible as a dependent unless you and your spouse provide information about the spouse’s employment status, including details about the spouse’s access to his or her own employer-sponsored health care.

If you are an active member whose spouse is employed and eligible to participate in a qualified employer-sponsored health plan, your spouse must enroll in the qualified plan offered through the spouse’s employer in order to be eligible for dependent benefits in this Plan. When your spouse has complied with this requirement, the plan of your spouse’s employer will be primary, and this Plan will be secondary for benefits due to the spouse. (See Coordination of Benefits on page 76 for information about primary and secondary coverage.)

For purposes of the spousal coverage rules, a “qualified” employer-sponsored health plan is a plan that:

- Is insured (or self-insured by the employer) and subject to regulation by state or federal agencies such as the U.S. Department of Labor or Internal Revenue Service; and
- Offers industry-recognized standard benefits for medically necessary hospitalization, surgery and outpatient medical treatment and prescription drug coverage.

If a working spouse has multiple coverage options, he or she is required to enroll in at least single coverage (for the spouse only) at the standard benefit level of a qualified plan (not high-deductible or limited coverage), as well as prescription drug coverage if offered.

A spouse is not required to elect dental or vision benefits, or family coverage. However, if the Trustees determine that it would be in the interest of this Plan to do so, they may require a working spouse to enroll any dependent children in the spouse’s health plan, provided that this Plan pays the additional premium that the spouse would be required to pay for the dependent children.

There are certain exceptions to the spousal coverage requirements. A working spouse is not required to enroll in an employer-sponsored plan in order to maintain eligibility in this Plan in any of the following situations:

- If the spouse is self-employed and has no other employees.
- If the spouse works only part-time (less than 30 hours per week or less than 130 hours per month).
- If the spouse’s employer does not contribute toward the cost of the spouse’s health coverage, requiring the spouse to pay 100% of the cost.
- If the Trustees determine that due to unusual and unforeseen circumstances, enrollment by the spouse would impose extreme hardship. (So long as the spouse’s employer also contributes to the cost of the spouse’s coverage under his or her own employer-sponsored plan, enrollment will not ordinarily be deemed an extreme hardship.)

Facilitation and verification of spousal enrollment: The Benefit Plans Administrator is authorized to terminate eligibility of a dependent spouse for benefits from this Plan if necessary to enable your spouse to enroll in the plan of the spouse’s employer, and to reinstate eligibility in this Plan after your spouse’s enrollment in that employer-sponsored plan has taken place.

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 that the spouse’s application was made in time to prevent loss of eligibility.

The Trustees may require written verification from a working spouse’s employer that any of the requirements of this Plan for maintaining working spouse eligibility have been satisfied. For example, the Trustees may request verification of the type of health coverage offered by the employer, the employer’s contribution to the cost of coverage, the date and type of coverage elected by the spouse, the spouse’s hours of employment, or other relevant information.

If an active member’s working spouse fails to enroll in an employer-sponsored health plan when required, or if the member, spouse or spouse’s employer fails to provide required information requested by the Plan, the spouse’s eligibility for benefits in this Plan will terminate. If the spouse thereafter enrolls in the spouse’s employer-sponsored health plan, or if the required information is provided, the spouse’s eligibility in this Plan will be reinstated at the
beginning of the month following the month in which the enrollment or information is completed, but not retroactively.

**Dependent Child Eligibility**

For purposes of eligibility in this Plan, your dependent child is any of the following, provided that the child is your “child” or “dependent” as defined in Section 105(b) of the Internal Revenue Code:

- A natural child;
- A child adopted by judicial decree;
- A child legally placed for adoption in your home;
- A child for whom the Plan is required to provide coverage pursuant to a Qualified Medical Child Support Order (QMSCO);
- Your stepchild, as long as the child’s natural parent is your spouse. If your stepchild is covered under a health plan of either natural parent, this Plan’s coverage of the stepchild will be secondary to the natural parent’s plan.

Your child is eligible for dependent coverage until the last day of the calendar month in which the child’s 26th birthday occurs.

Your child may remain eligible for dependent coverage past the child’s 26th birthday if the child is totally disabled and you rightfully claim a deduction for the child on your federal income tax return.

For continued coverage of a totally disabled child age 26 and over, substantiation of the child’s disability will be required by the Plan no later than 31 days after the child’s 26th birthday and periodically thereafter as requested by the Plan.

**Opting Out of Dependent Coverage**

Any dependent eligible for coverage may opt out of coverage by signed written notice to the Trustees, specifying the date on which coverage may terminate. Any dependent who has voluntarily terminated dependent coverage may reinstate coverage by written notice to the Trustees, provided that the dependent qualifies for 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 age 18 or older or a spouse must request to opt out of the Plan individually.

**Termination of Dependent Eligibility**

Except as provided for a dependent who has elected COBRA (see page 71), eligibility of a member’s dependent will automatically end on the last day of the month in which the earliest of the following dates occurs:

- The date the member’s eligibility ends, except as follows:
  - Eligibility of dependents of a member in the non-active classification will not terminate solely because the member becomes entitled to Medicare, so long as the member is enrolled in the UHC Medicare Advantage Program.
  - In the event of a member’s death while covered in the Outside or Inside Eligibility class, the member’s dependents will remain covered until the end of the third month after the month in which the death occurred, or if later, until the end of the eligibility period earned by the member’s credit hours as of the date of death.
- The date the individual no longer qualifies as an eligible dependent under the terms of the Plan.
- The date the dependent falsifies any information in connection with a claim for benefits or commits any action with the intent to defraud the Plan.
- The date the Plan terminates.

**When Coverage Ends**

You have options for continuing coverage when your coverage under the Plan is about to end. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and your dependents have the right to continue coverage under the Plan in lieu of minimum/difference payments if you (or your enrolled dependents) would otherwise lose coverage due to certain qualifying events such as termination of employment, death, or certain other qualifying events. For details, see COBRA Continuation Coverage on page 71.
The Medical Benefit

The Plan’s comprehensive coverage for medical care includes a wide range of health care services and supplies used to diagnose and treat injury or sickness, and to help you maintain good health. This chapter describes the Medical Benefit in detail; note that separate chapters describe prescription drug, vision care and dental care coverage.

Levels of Benefits

There are two schedules of medical benefits within the Plan, the Platinum Schedule and the Gold Schedule.

The schedule applicable to you and your dependents depends on the rate at which your employer is contractually obligated to contribute to the Plan. (See Schedule of Medical Benefits on page 19.)

Platinum Schedule of Benefits

The Platinum Schedule is the highest level of medical benefits, providing generally 90% medical coinsurance (coinsurance is the percentage of the allowable amount you must pay after any deductible and before the Plan starts paying benefits). If you and your dependents are in the active classification and covered under the Platinum Schedule, you will continue to be covered under the Gold Schedule after entering the non-active classification, until you are eligible for Medicare.

Gold Schedule of Benefits

The Gold Schedule is a high level of medical benefits (providing generally 80% medical coinsurance). If an active member’s employer is contractually obligated to contribute at the Gold Schedule rate, the member and dependents are covered under the Gold Schedule.

Network Providers

The Plan enters into contracts with medical network sponsors that allow covered persons to have access to networks of hospitals, physicians, and other health care providers. In general, the Plan’s benefits will be higher for an in-network provider than for an out-of-network provider. Covered persons are generally free to obtain most medical services and supplies from either an in-network provider or an out-of-network provider. However, certain services are covered under the Platinum and Gold Schedules only if obtained from an in-network provider, as noted under What’s Covered Under the Plan on page 21.

If you choose an in-network provider, the Plan’s benefits covered under either the Platinum Schedule or the Gold Schedule are higher than if you choose an out-of-network provider. In addition, in-network providers may not charge more than the amount contractually agreed with the network sponsor, and may not require covered persons to pay more than the copayment, or the deductible and coinsurance share, based on that amount.

If you choose an out-of-network provider, the Plan’s benefits covered under either the Platinum Schedule or the Gold Schedule are lower than for an in-network provider, and are subject to the Plan’s reasonable and customary limitation. An out-of-network provider is not limited in the amount it can charge a covered person after receiving the Plan’s benefits.
Determination of Benefit Amounts

Allowable Amount

The Plan bases its coverage in part on a determination of the allowable amount for covered services. The allowable amount is the maximum benefit that the Plan would pay on a claim if no deductible or copayment 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 member of the network (that is, an in-network provider will never charge an amount greater than the allowable amount). For a charge from an out-of-network provider, the allowable amount is the lesser of the amount actually 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 Limit

Charges from in-network providers are the uniform charge dictated under the provider’s contract with the network. As a result, in-network providers’ charges always conform to the Plan’s allowable amount for covered charges. Out-of-network providers, however, are not bound by the network’s terms and may charge amounts greater than the allowable amount for covered charges.

In these cases, the Plan bases its benefits on a reasonable and customary allowance — in general, this means an amount determined by the Plan to be a reasonable charge for a covered out-of-network service. Under the Plan, the reasonable and customary amount for any covered service is equal to 100% of the Medicare-approved amount for that service. In the case of services and supplies covered by the Plan but not covered by Medicare, the Trustees have discretion to determine the method by which the reasonable and customary amount will be established. To make this determination, they may rely upon data furnished by appropriate outside professional sources. The amount of an out-of-network provider’s charge deemed to be in excess of the reasonable and customary amount will not be covered by the Plan — it remains the member’s responsibility.
Deductibles

The Plan’s deductible is an annual amount that you must pay toward allowable claims before Plan benefits become payable — in other words, the deductible is the amount you are responsible for spending each year before the Plan begins paying a portion of certain covered expenses.

The individual deductible is the amount that must be paid on behalf of any covered person before Plan benefits will be paid for that person, until the family deductible is satisfied. The family deductible is the deductible amount that, once paid for any combination of a member and the member’s dependents, satisfies the individual deductible for the member and all of the member’s dependents for the remainder of the calendar year.

Note that eligible preventive care services, as described under Preventive Services and Supplies on page 29, are covered under the Plan even if you have not met the annual deductible.

Note also that under both the Platinum Schedule and the Gold Schedule, there are separate annual deductibles for in-network and out-of-network care. Amounts you pay toward the in-network deductible do not count toward meeting the out-of-network deductible, or vice versa.

Copayments

A copayment (or copay) is a fixed dollar charge that you must pay for certain covered services under the Plan even though the deductible has been met (see the Schedule of Medical Benefits on page 19). When copayments are required for a particular service, no coinsurance will also be charged for that service. If you meet the out-of-pocket maximum associated with your coverage, copays will no longer be required when you see in-network providers for the rest of the calendar year.

Coinsurance

After any applicable deductible is satisfied, and after the Plan pays its coinsurance percentage share for a particular service or supply (see the Schedule of Medical Benefits on page 19), your responsibility is the remaining percentage of the allowable amount. If you meet the out-of-pocket maximum associated with your coverage, the Plan will then pay 100% of allowable in-network expenses for the rest of the calendar year.

Out-of-Pocket Maximum

The out-of-pocket maximum for medical benefits is an annual cap on the amount each covered person has to pay for allowable in-network expenses in a given Plan year. In-network deductibles, copays and coinsurance all apply toward the in-network annual out-of-pocket maximum.

The individual out-of-pocket maximum is satisfied for the rest of the calendar year when the sum of all deductibles, copayments, and coinsurance shares paid by a covered person for in-network services in a calendar year equals the individual out-of-pocket maximum stated in the Schedule of Medical Benefits (see page 19). When the combined amount of such payments made in a calendar year for any combination of a member and the member’s dependents equals the family out-of-pocket maximum, the individual out-of-pocket maximum is satisfied for the member and all of the member’s dependents for in-network services for the rest of the same calendar year. Eligible in-network expenses submitted for reimbursement after the annual out-of-pocket maximum is reached are paid at 100% of the allowable amount.
Amounts paid for out-of-network services do not count toward satisfying the out-of-pocket maximum. In addition, certain charges remain the covered person’s responsibility even after the out-of-pocket maximum has been met, including the following:

- Charges for services and supplies not covered by the Plan;
- Charges from an out-of-network provider in excess of the Plan’s allowable amount;
- Charges from an out-of-network provider for which no Plan benefits are paid because of failure to obtain required prior authorization; and
- Charges in excess of Plan benefits for services and supplies within the Prescription Drug Benefit, the Dental Benefit or the Vision Benefit.

**Specific Plan Limits**

Plan limits apply on certain benefits, such as for the number of chiropractic visits eligible for coverage in a calendar year. These limits are spelled out in the Schedule of Medical Benefits (see page 19). Bear in mind that services in excess of the stated limits are not covered under the Plan.

**Benefit Payable**

The benefit payable by the Plan for an allowable claim is the allowable amount, less the copayment (where required), less any unsatisfied amount of any applicable deductible, multiplied by the applicable coinsurance percentage, subject to any specific limitations. If you have met an applicable out-of-pocket maximum, the benefit payable is the entire allowable amount, subject to any specific limitations.

For the preventive services described in Preventive Services and Supplies on page 29, the benefit payable by the Plan is the allowable amount — i.e., eligible preventive services are paid at 100% with no deductible.
### Schedule of Medical Benefits

<table>
<thead>
<tr>
<th>PLAN PROVISION</th>
<th>HOW IT WORKS</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Platinum Plan</td>
<td>Gold Plan</td>
</tr>
<tr>
<td>Annual deductible</td>
<td>$200/Individual $600/Family</td>
<td>$300/Individual $900/Family</td>
</tr>
<tr>
<td></td>
<td>Platinum: $600/Individual $1,800/Family</td>
<td>Gold: $800/Individual $2,400/Family</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum</td>
<td>$2,000/Individual $6,000/Family</td>
<td>$3,100/Individual $9,700/Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90%</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### PREVENTIVE CARE
*Subject to age and frequency guidelines. See page 29 for a full list of covered preventive services.*

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Platinum Plan</th>
<th>Gold Plan</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine preventive care</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Annual physical</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Well-woman visits</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Well-child care</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Screenings and diagnostic tests</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Routine mammography</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung cancer screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other preventive screenings and tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>50%, no deductible</td>
</tr>
</tbody>
</table>

#### DOCTORS’ OFFICE VISITS
*Including diagnostic x-rays and tests performed in the doctor’s office.*

<table>
<thead>
<tr>
<th>Doctor's Office Visit</th>
<th>Platinum Plan</th>
<th>Gold Plan</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care physician</td>
<td>$25 copay</td>
<td>$25 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$50 copay</td>
<td>$50 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>50%, no deductible</td>
</tr>
</tbody>
</table>

#### HOSPITAL SERVICES
*Benefits stated are as of May 1, 2015. For services prior to that date, Plan pays a maximum of $42 per visit.*

<table>
<thead>
<tr>
<th>Hospital Service</th>
<th>Platinum Plan</th>
<th>Gold Plan</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Routine nursery care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Diagnostic, radiology, laboratory and pathology</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Physician and specialist services</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Surgery</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>PLAN PROVISION</td>
<td>HOW IT WORKS</td>
<td>Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Platinum Plan</td>
<td>Gold Plan</td>
<td></td>
</tr>
<tr>
<td>EMERGENCY AND URGENT CARE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$250 copay</td>
<td>$300 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Platinum: $250 copay</td>
<td>Gold: $300 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copay waived if admitted to hospital, but hospital coverage provisions will then apply. No benefits are payable if you use the emergency room for non-emergency care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Ambulance (ground)</td>
<td>$150 copay</td>
<td>$300 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Platinum: $150 copay</td>
<td>Gold: $300 copay</td>
<td></td>
</tr>
<tr>
<td>Ambulance (air or water)</td>
<td>$1,000 copay</td>
<td>$1,000 copay*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Certain services require prior authorization. See page 34.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>OTHER COVERED SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Certain services require prior authorization. See page 34.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Home health care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Hospice care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Diagnostic, radiology, laboratory and pathology at standalone outpatient facility</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Short-term rehabilitation (physical, speech and occupational therapy)</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
<tr>
<td>Convalescent skilled nursing facility</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
<td>50% after deductible*</td>
</tr>
</tbody>
</table>

*Patient’s responsibility to secure required prior authorization. See page 34.
What’s Covered Under the Plan

The Plan covers a comprehensive range of services and supplies, as described on the following pages. Except as specifically noted, the Plan covers only listed services and supplies that are:

- Medically necessary, unless included in the Preventive Services and Supplies section on page 29;
- Performed or ordered and supervised by a physician or other medical professional as noted; and
- Not excluded from coverage, as detailed under General Medical Exclusions and Limitations on page 31.

Non-Preventive Services and Supplies

Note that services or supplies included in this section are generally eligible for coverage under the Platinum and Gold Schedules of Benefits, with stated limitations. However, inclusion in this section does not guarantee whether, or to what extent, benefits are payable.

**Abortion:** 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. Elective abortions are excluded except as stated. Prior authorization is required.

**Allergy care:** The Plan covers testing, diagnosis and treatment when prescribed and/or administered by a physician, including injections and prescribed medications.

**Ambulance services:** The Plan covers emergency ground medical transport services when all of the following criteria are met:

- The medical transport services complies with all local, state and federal laws and has all appropriate licenses and permits;
- The ambulance has the necessary patient care equipment and supplies;
- The patient’s condition is such that any other form of transportation is medically contraindicated; and
- The patient is transported to the nearest hospital with the appropriate facilities for the treatment of the patient’s illness or injury or, in the case of an organ transplant, to the pre-authorized transplant facility.

Air or water ambulance is covered only when all the above criteria are met and at least one of the following circumstances applies:

- 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, rapid ambulance transport unachievable by land ambulance;
- The point of pickup is inaccessible to a land vehicle;
- Great distances, limited time frames, or other obstacles to land transport would prevent getting the patient to the nearest hospital with appropriate facilities for treatment.

Prior authorization is required for non-emergency transportation from one medical facility to another. Air or water transport to the nearest facility equipped to handle the emergency is covered only for the lowest cost aircraft/vessel that is available and appropriate for the patient’s medical condition.

**Anesthesia:** The Plan covers anesthesia when administered by a physician or qualified health professional in connection with a medically necessary covered procedure.

**Assistant surgeon:** The Plan covers the services of an assistant surgeon when the type of surgery dictates that the primary surgeon requires assistance, according to generally accepted medical practice. The allowable amount for an assistant surgeon’s charges is reduced from the allowable amount for the primary surgeon.

**Blood:** The Plan covers the administration, storage and processing of blood and blood products in connection with covered services and supplies. Harvesting and storage of a patient’s own blood are not covered, except for potential use in a covered, scheduled surgical procedure. Harvesting and storage of fetal cord blood are not covered.

**Brachytherapy:** The Plan covers brachytherapy, or internal radiotherapy. Prior authorization is required.
Breast reconstruction: The Plan covers breast reconstruction and prosthesis following a medically necessary mastectomy, including nipple reconstruction, augmentation or reduction of the affected breast; augmentation or reduction of the opposite breast to restore symmetry; internal or external prostheses; and treatment of complications of all stages of mastectomy, including lymphedemas. Reconstructive procedures that are performed primarily for cosmetic or beautifying purposes or are not medically necessary are not covered.

Cardiac diagnostic testing: The Plan covers cardiac diagnostic testing when medically necessary to determine diagnosis; examples include angiography, cardiac catheterizations, radio frequency ablations, cardiac stress imaging and stress echocardiograms. Prior authorization is required.

Cardiac rehabilitation therapy: The Plan covers cardiac rehabilitation therapy following cardiac surgery or disease to restore health as much as possible through exercise and education. Limited to 36 visits per calendar year.

Chemotherapy and radiation therapy: The Plan covers standard chemotherapy and radiation therapy, including intensity-modulated radiation therapy (IMRT), stereotactic radiation therapy, proton beam therapy, and dose-intensive chemotherapy. Prior authorization is required.

Chiropractic services: The Plan covers chiropractic therapy within the scope of provider’s license, including initial diagnosis and supplies. Effective May 1, 2015, benefits are limited to 40 visits per calendar year — combined network and out-of-network providers — with no per-visit dollar limit or annual dollar limit. (Prior to May 1, 2015, benefits are limited to $42 per visit and $1,500 annually.)

Clinical trials: The Plan covers routine patient care furnished in connection with participation in Phase I, II, III or IV clinical trials undertaken for the purposes of the prevention, early detection, or treatment of cancer. The clinical trial must be conducted at an academic or National Cancer Institute center and be approved or funded by one the following entities:

- National Institute of Health (NIH);
- An NIH cooperative group or center;
- The FDA in the form of an investigational new drug application;
- The U.S. Departments of Veterans Affairs or Defense;
- A qualified research entity that meets the criteria for NIH center support grant eligibility; or
- An institutional review board that has an appropriate assurance approved by the Department of Health and Human Services.

Prior authorization is required. Coverage excludes non-health care services required in conjunction with the trial (e.g., transportation, lodging, custodial care); costs associated with administration of the trial, data collection or analysis; or items that would not be covered for reasons other than being experimental or investigational.

Cosmetic, plastic and related reconstructive surgery: The Plan covers surgical correction of congenital birth defects or the effects of disease or injury, provided that the surgical procedure:

- repairs defects resulting from an accident within one year of the accident or as soon as medically appropriate;
- replaces diseased tissue surgically removed, within one year of the surgery or as soon as medically appropriate;
- treats a birth defect in a child as soon as medically appropriate; or
- is covered under the Plan’s criteria for breast reconstruction following a covered mastectomy. See also Breast reconstruction above.
Prior authorization is required. Services or supplies that are not obtained as soon as medically appropriate are not covered. Cosmetic or reconstructive procedures that alter appearance but do not restore or improve impaired physical function, except as expressly listed, are not covered.

**Dental procedures:** The Plan covers administration of general anesthesia in any facility and hospital charges for dental care provided to children under the age of five, who are severely disabled or have a medical or behavioral conditions requiring hospitalization or general anesthesia when dental care is provided. Prior authorization is required.

Except as provided above, the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery for impacted teeth, surgery involving structures directly supporting the teeth, dental implants or orthodontia, oral surgical procedures (including services for overbite or underbite, whether the services are considered to be medical or dental in nature, are not covered in the Medical Benefit. In addition, dental x-rays, supplies, and appliances (including occlusal splints and orthodontia), removal of dentiginous cysts, mandibular tori and odontoid cysts, and removal of teeth due to an injury, prior to radiation or for radioncerosis, are also not covered in the Medical Benefit, but may be covered in the Plan’s Dental Benefit.

See also **Oral surgery and diseases of the mouth** on page 26.

**Dermatological care:** 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. Cosmetic procedures, except as indicated, are not covered.

**Diagnostic and treatment services:** The Plan covers the following services rendered by a physician, whether in or out of the physician’s office:

- Diagnosis and treatment of covered illness or injury.
- Administration of Injectable medication normally rendered in a Physician’s office.
- Consultations with specialists.
- Performance of laboratory tests.

See also **Laboratory services** on page 25.

**Dialysis:** The Plan covers hemodialysis and peritoneal services provided by outpatient or inpatient facilities, or at home only if patient is homebound. For home dialysis, equipment, supplies, and maintenance are covered. Prior authorization is required.

**Diabetic supplies:** The Plan covers approved glucose meters, insulin pumps and cartridges, and self-management training used in connection with the treatment of diabetes. Prior authorization is required. Disposable insulin syringes, glucose strips, and lancets are not covered in the Medical Benefit, but may be covered under the Prescription Drug Benefit.

**Durable medical equipment (DME):** The Plan covers ***durable medical equipment (DME)*** that is determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part, and when all of the following circumstances apply:

- It can withstand repeated use;
- It is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of illness or injury;
- It is appropriate for use in the home; and
- It does not exceed the minimum specifications that are medically necessary.

Prior authorization is required. Coverage is for DME rental if rental is not expected to exceed the purchase price, or for purchase if rental is expected to exceed the price. DME must be ordered by or provided under the direction of a physician for use outside a hospital or **skilled nursing facility.** Covered DME can include wheelchairs, standard hospital beds, continuous passive motion devices, initial purchase of elastic garments, oxygen and equipment for the administration of oxygen, mechanical equipment necessary for the treatment of chronic or acute respiratory failure (ventilators and respirators), and insulin pumps.
DME upgrades are not covered unless medically necessary because of a change in the patient’s condition. Replacement of purchased equipment that has become non-functional and non-repairable due to routine use is covered only after five years from date of purchase (or the expected functional life of the item if less than five years).

**Durable Medical Equipment (DME) supplies:** The Plan covers non-disposable supplies needed for use of covered DME. Supplies related to a TENS unit are covered with the initial purchase of the TENS unit. Over-the-counter and disposable supplies are not covered.

**Emergency services:** The Plan covers services and supplies furnished or required to screen and stabilize an emergency medical condition, when provided on an outpatient basis at either a hospital or alternate facility. No benefits are payable for non-emergency services received in the emergency room.

See also **Urgent care services** on page 29.

---

**IMPORTANT**

Emergency services and urgent care services are covered by the Plan when you use the appropriate facility. Non-emergency use of the emergency room may result in denial of benefits, so it’s important to remember when it’s appropriate to go to the emergency room and when it’s preferable to use an urgent care facility.

A hospital’s emergency room is **only** for emergency medical conditions — that is, conditions whose symptoms are so severe that absence of immediate medical attention could put the patient’s health in grave danger. Severe chest pains and seizures are examples of emergency conditions.

An urgent care facility is for medical conditions that require prompt treatment but are not serious enough to require immediate hospital-level care. Examples include cuts and chronic earaches.

---

**Enteral tube feeding:** The Plan covers enteral or parenteral nutrition. Prior authorization is required. Nutritional support taken orally is not covered.

**Eyeglasses and corrective lenses:** The Medical Benefit of the Plan covers only the first pair of eyeglasses or corrective lenses following cataract surgery. For information about routine coverage for eyeglasses or corrective lenses, see The Vision Benefit on page 53.

**Genetic testing and counseling:** The Plan covers genetic testing, counseling and studies for diagnosis or treatment of genetic abnormalities. Prior authorization is required.

**Home health care services:** The Plan covers home health care services delivered through a **home health agency** only when all of the following requirements are met:

- Services are a type that can be performed only by a licensed nurse, physical therapist, speech therapist, or occupational therapist;
- The services are a substitute or an alternative to hospitalization;
- The services are part-time and intermittent;
- A treatment plan has been established and periodically reviewed by the ordering physician;
- The agency rendering services is Medicare-certified and licensed by the state of location; and
- The patient is homebound or confined in a custodial setting.

Prior authorization is required. Home health visits are limited to 100 visits per calendar year (combined network and out-of-network providers). A home visit is defined as four hours or less.

**Hospice:** The Plan covers hospice care rendered for treatment of a covered person who has a prognosis of six months or less to live, when such care is provided through a **hospice agency** or **hospice care program** and includes supportive care involving the evaluation of the emotional, social and environmental circumstance related to or resulting from the illness, and guidance and assistance in preparing the patient and the patient’s family for imminent death.
Hyperbaric oxygen therapy (HBOT): The Plan covers hyperbaric oxygen therapy. Prior authorization is required.

Implants and related services: The Plan covers implant devices and related implantation services including pacemakers, joint replacements, AEDs, implantable TENS units, spinal braces, penile implants (unless prescribed to treat impotence which is psychological in origin), and implants for the delivery of prescription medication. Prior authorization is required. Penile implants are limited to one per lifetime. Replacement of covered implants is covered only when medically necessary due to a change in the patient’s condition.

Impotence: The Plan covers treatment for male organic impotence. Treatment for male psychogenic impotence is covered only under the Mental Health Benefit.

Infertility diagnosis: The Plan covers diagnostic studies leading to an infertility diagnosis with prior authorization. Treatment of infertility is not covered.

Injectable medications: The Plan covers injectable medications when FDA-approved for the patient’s disease or condition and administered by an appropriately licensed medical professional. Self-injectable medications are not covered under the Medical Benefit but may be available under the Prescription Drug Benefit.

Inpatient hospital care: The Plan covers semi-private accommodations; intensive care unit or coronary care unit, as appropriate; general nursing care; operating room, surgical and anesthesia services and supplies; blood and blood products; ordinary casts, splints and dressings; all drugs and oxygen used in hospital; laboratory and X-ray examinations; electrocardiograms. Consistent with the Plan’s utilization management policy, all acute care hospital admissions and continued stays are reviewed for medical necessity during the inpatient stay. Prior authorization is required, except for maternity admission that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Personal comfort and convenience items (such as guest services or non-patient meals while hospitalized) are not covered.

Laboratory services: The Plan covers laboratory services within the standard of care for the particular diagnosis. Prior authorization is required for genetic testing. Coverage is limited to services that are less costly and likely to produce results equivalent to the prescribed services, when clinically appropriate.

Mastectomy: The Plan covers mastectomy. Prior authorization is required. See also Breast reconstruction on page 22.

Maternity services: The Plan covers maternity-related medical, hospital and other covered services and supplies for the mother and her newborn child, including up to 48 hours of inpatient post-natal maternity care for vaginal delivery and 96 hours of inpatient post-natal maternity care for cesarean delivery. If there is a shorter length of stay, post-discharge care is covered as follows: Up to two visits, at least one of which may be in the home, in accordance with maternal and neonatal physical assessments, by a physician or a registered professional nurse with experience in maternal and child health nursing. Services of certified and licensed midwives are covered in the states in which they practice. Home delivery is not covered by the Plan. Notification and prior authorization are required for an inpatient stay beyond 48 hours after vaginal delivery or 96 hours after a cesarean delivery.

Medical complications: The Plan covers treatment of complications arising from a covered surgical procedure. Prior authorization is required. The Plan does not cover treatment of complications resulting from failure to follow the prescribed course of treatment, or complications arising from a service or supply not covered by the Plan.

Member Assistance Program (MAP): The Plan covers confidential counseling services in the following areas, regardless of whether they are considered medically necessary:

- Stress management
- Legal problems
- Positive drug/alcohol test
- Marital and family counseling
- Parenting
- Anxiety, depression and grief

Services are offered solely through the Mercy Member Assistance Program and covered at no cost to the member (coverage is limited to six visits per issue). To obtain services through the MAP call 314-729-4600 or toll-free at 800-413-8008.
Mental health and substance abuse services: The Plan covers services and supplies for diagnosis and treatment of mental health and substance abuse conditions, subject to all limitations and restrictions of the Plan. In-network providers for these services and supplies are limited to those providers in the Plan’s mental health and substance abuse network. Prior authorization is required for all facility services.

Newborn inpatient care after discharge: The Plan covers services and supplies as medically appropriate for care of newborns. The Plan also covers services and supplies for diagnosis and treatment of conditions unique to newborns, such as 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. Such coverage is subject to all limitations and restrictions of the Plan. Prior authorization is required.

Observation stays: The Plan covers hospital observation stays as an alternative to inpatient hospital admission. Prior authorization is required.

Office visits: The Plan covers services and supplies appropriately provided during an office visit to a physician, including but not limited to:

- Diagnosis and treatment of illness or injury.
- Injectable medication requiring supervision from a health care professional, normally rendered in a physician’s office.
- Consultations with specialists.

Self-injectable medications are not covered.

Oral surgery and diseases of the mouth: The Plan covers oral surgery and diseases of the mouth as follows:

- Removal of tumors and cysts of the jaw, lips, cheeks, tongue, roof and floor of mouth, and removal of bony growths of the jaw, soft and hard palate.
- Service and supplies for oral surgery, limited to the reduction or manipulation of fractures of facial bones; excisions of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect.
- Diseases of the mouth, except dental disease or disease of dental origin.
- Diagnosis and surgical treatment for temporomandibular joint disorder (TMJ) and craniomandibular joint disorder.
- Non-surgical treatment of TMJ including evaluation, X-rays, removable non-orthodontic appliance, therapy, minor procedures for occlusal equilibration or adjustments, treatment of muscle spasms and injections.

Prior authorization is required. The Plan’s Medical Benefit does not cover dental diseases or services and supplies covered under the Dental Benefit. Orthodontic treatment of TMJ and related appliances are not covered. Services and supplies required for treatment of an accidental injury to teeth are excluded, but may be covered under the Plan’s Dental Benefit.

See also Dental procedures on page 23.

Orthotics for feet: The Plan covers custom-made foot orthotics. Replacement orthotics are covered if prescribed by a physician and medically necessary due to a change in the patient’s physical condition. New and replacement orthotics are limited to $1,000 per covered person per calendar year. Over-the-counter orthotics or other inserts not custom-made for the patient are not covered.
Outpatient diagnostic tests and therapeutic treatments: The Plan covers prescheduled outpatient diagnostic tests and therapeutic treatments, including but not limited to CT scans, PET scans, ultrasound, echocardiogram, MRI and MRA, chemotherapy, and radiation therapy. The tests or treatments must be ordered by an attending physician and performed at a hospital or alternate site that is licensed and appropriate for the service. Prior authorization is required for all tests and treatments specified in a list maintained by the Plan and available by calling the Benefit Office or visiting the Plan’s website at www.carpdc.org/BenefitServices.

Outpatient surgery: The Plan covers prescheduled outpatient surgery performed at a hospital or alternate facility under the direction of an attending physician. Prior authorization is not required for tubal ligation, tonsillectomy, adenoidecmy, myringotomy tubes and breast biopsy. Prior authorization is required for all outpatient surgical procedures specified in a list maintained by the Plan and available by calling the Benefit Office or visiting the Plan’s website at www.carpdc.coventryhealthcare.com. Experimental or investigational surgical procedures or devices are not covered.

Pain management: The Plan covers pain management services and supplies, and pain management injections (including epidural, trigger point and facet injections). Prior authorization is required.

Phenylketonuria (PKU) and similar inherited conditions: The Plan covers formula and low-protein modified food products used for PKU and other inherited amino and organic acid-related conditions, when prescribed by a physician. Prior authorization is required. Coverage is limited to children under the age of 6.

Podiatry: The Plan covers services of a podiatrist including, without limitation, foot care obtained in connection with a diagnosis of diabetes, such as clipping nails or treating corns and calluses. Lithotripsy for treatment of plantar fasciitis and over-the-counter inserts are not covered.

Pregnancy care: The Plan covers diagnosis and treatment of pregnancy on the same basis as an illness or injury. Prior authorization is required for an inpatient stay beyond 48 hours after vaginal delivery or 96 hours after a cesarean delivery. Notification of pregnancy in the first trimester is recommended. See also Covered Preventive Services for Women, Including Pregnant Women on page 30.

Preventive services: See Preventive Services and Supplies on page 29.

Prosthetic devices and braces: The Plan covers prescribed prosthetics for initial replacement of a lost natural body part, including but not limited to artificial limbs, breasts, and eyes, limited to the basic functional device that will restore the lost body function or part. For placements requiring an initial temporary placement followed by a permanent placement, only one device will be covered. Replacement of a prosthesis furnished by the Plan, except breast prosthesis, will be covered only if it becomes non-functional and non-repairable due to routine use, or is medically necessary due to a physical change on the part of the patient. For breast prosthetics, replacement will be covered if determined necessary by the patient’s physician. Splints and braces, other than dental braces, are covered, including necessary adjustments to shoes to accommodate leg braces.

Prior authorization is required for prosthetic devices over $10,000, and for refitting or replacements. Over-the-counter braces, splints and prosthetics are not covered.

See also Orthotics for feet on page 26.

Pulmonary rehabilitation therapy: The Plan covers pulmonary rehabilitation therapy, limited to 12 visits per calendar year.

Radiology: The Plan covers radiology services and supplies. Prior authorization is required for radiology services and supplies specified in a list maintained by the Plan and available by calling the Benefit Office or visiting the Plan’s website at www.carpdc.coventryhealthcare.com.

Reconstructive surgery: See Breast reconstruction and Cosmetic, plastic and related reconstructive surgery on page 22.
Rehabilitation services and visits: The Plan covers physical therapy, occupational therapy, and speech therapy prescribed by attending physician, provided in an outpatient setting by a physical therapist or occupational therapist, and for speech therapy by a speech pathologist, audiologist or speech/language pathologist, practicing within the scope of their respective licenses. Limited to 60 visits per year, all types of therapy combined.

The Plan does not cover:
- Rehabilitative services provided for long-term, chronic medical conditions.
- Rehabilitative services whose primary goal is to maintain patient’s current level of function, as opposed to improving functional status.
- Educational or vocational therapy designed to retrain patient for employment.
- Rehabilitative services intended to improve a developmental or learning disability or delay.
- Alternative rehabilitation services such as massage therapy.
- Services and supplies whose usual purpose is nontherapeutic exercise, including but not limited to health clubs, fitness centers, weight loss centers or clinics, and home exercise equipment.

See Home health care services on page 24 for therapy administered at home or in a custodial setting.


Sleep studies: The Plan covers sleep studies to diagnose obstructive sleep apnea. Prior authorization is required.

Skilled nursing facility services: The Plan covers confinement in a skilled nursing facility, together with medical services and supplies provided in the facility. Coverage is provided only for care and treatment that cannot be safely or effectively provided in an outpatient setting, as determined by the Plan. Prior authorization is required. Coverage is for semi-private accommodations only and limited to a maximum of 100 days per calendar year.

Sterilization: The Plan covers vasectomy obtained in an office setting. Tubal ligation is covered as a preventive benefit; see Covered Preventive Services for Women, Including Pregnant Women on page 30. Reversal of vasectomy or tubal ligation is not covered.


Transplants (organ): The Plan covers services and supplies for organ transplants only if the transplant procedures are provided in the Plan’s transplant network. Prior authorization is required. Transplant services provided by a provider outside the transplant network are not covered.

Transplant travel benefit are available to and from a facility in the transplant network for evaluation and transplant services, for a member undergoing the transplant, his or her spouse or significant other, and the living donor. The Plan covers lodging, meal charges and transportation costs if the following conditions are met:
- The Carpenters’ Health and Welfare Trust Fund is the primary benefit payer;
- An approved facility within the transplant network is used;
- The patient and living donor live greater than 50 miles one way from the approved facility; and
- Transplant travel pertains to travel within the United States.

Air travel is recommended when the member and living donor live greater than 150 miles one way from the approved facility. Auto mileage is reimbursed at the current IRS approved mileage rate in effect from the start date of the evaluation appointment with the transplant facility to 12 months following the discharge date from the transplant facility post-transplant. Reasonable expenses as determined by the Trustees are covered for parking, taxi and shuttle buses.

Prior authorization for transplant-related travel expenses is required. Total available travel benefit per transplant is $10,000. Accumulation of benefits begins with the start date of the evaluation appointment with the transplant facility to 12 months following discharge from the transplant facility, post-transplant. Meal reimbursements are limited to $25 per day per person. Lodging is limited to $90 per day for member and $90 per day for the living donor. Maximum total lodging per day is $180 if two people accompany a child transplant member. Air travel is limited to the transplant member, plus one other person or for both parents if for child transplant member.
**Urgent care services:** The Plan covers urgent care services provided at an Alternate Facility such as an urgent care center.

See also **Emergency services** on page 24.

**Preventive Services and Supplies**

The preventive services and supplies listed below are eligible for coverage under the Platinum and Gold Benefit Schedules regardless of medical necessity unless otherwise specified.

When you see an in-network provider, benefits for the preventive services and supplies listed below are payable without any cost sharing — in other words, the Plan pays the full cost of the services and supplies listed below, as long as you use an in-network provider for your care. If you receive in-network preventive care for eligible expenses that are **not** listed below, or if you receive preventive care for eligible expenses from out-of-network providers, your expenses will be paid like any other eligible medical expense.

The Plan’s preventive services and supplies listed below are intended to conform to all of the following:

- Recommendations of the United States Preventive Services Task Force with rating of A or B;
- Immunizations with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control; and
- For women, infants, children and adolescents, guidelines supported by the Health Resources and Services Administration.

The guidelines named above are collectively referred to from time to time in these pages as the “preventive recommendations.”

The services and supplies detailed in the lists that follow, when provided by a physician as part of an annual preventive exam, are covered under the Platinum and Gold Benefit Schedules to the extent and under the conditions specified in the preventive recommendation. A listed service or supply is covered once each calendar year unless otherwise stated. Note that many of these services are subject to guidelines by age, gender, and risk-factors.

### Covered Preventive Services for All Adults

- Abdominal aortic aneurysm: Once-per-lifetime screening for men of specified ages who have ever smoked
- Alcohol misuse: Screening and Counseling
- Aspirin (OTC): Covered only under the Prescription Drug Benefit
- Blood pressure screening
- Cholesterol: Screening for adults of specified ages or at higher risk
- Colorectal cancer: Screening for adults over 50 years of age
- Depression screening
- Type 2 diabetes: Screening for adults with high blood pressure
- Diet counseling: For adults at higher risk for chronic disease
- HIV: Screening for all adults at higher risk
- Immunization: In specified doses, for specified ages and populations:
  - Hepatitis A: if a risk factor is present
  - Hepatitis B: if a risk factor is present
  - Herpes zoster: for specified ages
  - Human papillomavirus
  - Influenza (flu shot)
  - Measles, mumps, rubella: for adults born in or after 1957 who lack documentation of one or more doses of MMR
  - Meningococcal: for first-year college students and patients with risk factors
  - Pneumococcal: over age 65, or if a risk factor is present
  - Tetanus, diphtheria, pertussis: for adults with unknown or incomplete history of prior vaccination
  - Varicella: for adults without evidence of immunity to varicella
  - Zoster: for adults age 60 or over or if a risk factor is present
- Lung cancer screening: for certain adults age 55–80 with history
- Obesity screening and counseling
● Sexually transmitted infection (STI): prevention counseling for adults at higher risk
● Tobacco use: Screening for all adults, and cessation interventions for tobacco users (cessation coverage is limited to the Plan’s approved program)
● Syphilis: Screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women
● Anemia: Routine screening for pregnant women
● Bacteriuria: Urinary tract or other infection screening for pregnant women
● BRCA counseling and genetic testing: For women at higher risk; prior authorization required
● Breast cancer chemoprevention counseling and risk-reduction medication without cost-sharing for women at higher risk
● Breast cancer mammography: One baseline screening age 35–39 and screenings every 1–2 years for women over 40
● Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Hospital-grade breast pumps are covered only as required by medical necessity guidelines issued by the United States Preventive Task Force.
● Cervical cancer: Screening for sexually active women
● Chlamydia infection: Screening for younger women and other women at higher risk
● Contraception: Food and Drug Administration–approved contraceptive methods, sterilization procedures (tubal ligation) and patient education and counseling. Oral contraceptives and some implantables are covered only under the Prescription Drug Benefit.
● Domestic and interpersonal violence screening and counseling
● Folic acid supplements for women who may become pregnant
● Gestational diabetes: Screening for women 24–28 weeks pregnant and those at high risk of developing gestational diabetes
● Gonorrhea: Screening for all women at higher risk
● Hepatitis B: Screening for pregnant women at their first prenatal visit
● Human immunodeficiency virus (HIV): Screening and counseling for sexually active women
● Human papillomavirus (HPV) DNA test: High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
● Osteoporosis: Screening for women over age 60 with specified risk factors
● Rh incompatibility: Screening for all pregnant women and follow-up testing for women at higher risk
● Tobacco use: Expanded counseling for pregnant tobacco users, in addition to benefits described above for all adults
● Sexually transmitted infections (STI): Counseling for sexually active women
● Syphilis: Screening for all pregnant women or other women at increased risk
● Well-woman office visits to obtain covered preventive services

Covered Preventive Services for Children
● Alcohol and drug use assessments for adolescents
● Autism screening for children at 18 and 24 months
● Behavioral assessments
● Blood pressure screening
● Cervical dysplasia screening for sexually active females
● Congenital hypothyroidism screening for newborns
● Depression screening for adolescents
● Developmental screening for children under age 3, and surveillance through childhood
● Dyslipidemia screening for children at higher risk of lipid disorders
● Fluoride chemoprevention supplements for children without fluoride in their water source (covered only under the Prescription Drug Benefit)
● Gonorrhea preventive medication for the eyes of all newborns.
● Hearing screening for all newborns.
● Height, weight and body mass index measurements
● Hematocrit or hemoglobin screening
● Hemoglobinopathies or sickle cell screening for newborns
● HIV screening for adolescents at higher risk
● Immunization in specified doses, for specified ages and populations:
  ► Diphtheria, tetanus, pertussis
  ► Haemophilus influenza type B
  ► Hepatitis A
  ► Hepatitis B
  ► Human papillomavirus
  ► Inactivated poliovirus
  ► Influenza (flu shot or nasal spray) based on recommendations of the Advisory Committee on Immunization Practices (ACIP), 2014‒2015
  ► Measles, mumps, rubella
  ► Meningococcal
  ► Pneumococcal
  ► Rotavirus
  ► Varicella
● Iron supplements for children ages 6 to 12 months at risk for anemia
● Lead screening for children at risk of exposure
● Medical history of all children throughout development
● Obesity screening and counseling
● Oral health risk assessment for young children
● Phenylketonuria (PKU) screening for this genetic disorder in newborns
● Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
● Tuberculin testing for children at higher risk of tuberculosis
● Vision screening

**General Medical Exclusions and Limitations**

In addition to limitations and exclusions listed elsewhere, the following list details services that are not covered under the Medical Benefit.

● Any service or supply not medically necessary for the treatment of a sickness or injury, or that exceeds in scope, duration or intensity, that level of care needed to provide safe, adequate and appropriate diagnosis or treatment, unless expressly noted under What’s Covered Under the Plan as being covered even if not deemed medically necessary.
● Any service or supply that is not described as a covered service or supply, or that directly or indirectly results from receiving a non-covered service or supply.
● Occupational or work-related injury or sickness, or any injury or sickness for which the covered person may be entitled to or receives benefits under any applicable workers’ compensation policy, occupational disease policy or similar law (including settlement of a claim).
● Any service or supply provided by a close relative or a person who resides with the covered person.
● Any treatment for a sickness or injury or other condition that is court-ordered, or is a condition of probation or parole.
● Any covered service or supply provided for a covered person’s health condition after the covered person has failed to comply with or complete the covered course of treatment prescribed by a provider for the same condition.
● A service or supply rendered outside the scope of any provider’s license.
● Acupuncture services and associated expenses of any kind, including but not limited to treatment of painful conditions or for anesthesia purposes.
● 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.
• Alternative therapies: Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing.

• Autopsy: Services and associated expenses related to the performance of autopsies.

• Biofeedback therapy used to control physiological processes such as muscle tension, blood pressure or heart rate.

• Braces or supports needed solely for athletic participation or employment.

• Charges that are over 12 months old from the incurred date when submitted for consideration to the Plan.

• Charges for completion of a claim form, for telephone conversations with a physician in place of an office visit, for writing a prescription or for medical summaries and preparing medical invoices.

• Christian Science practitioners’ services, with the exception of the Medicare-certified Religious Nonmedical Health Care Institution services.

• Cosmetic or reconstructive procedures and any related services or supplies that alter appearance but do not restore or improve impaired physical function, except as expressly listed in the What’s Covered Under the Plan section.

• Counseling services and treatment related to religious counseling, marital and relationship counseling, vocational or employment counseling and sex therapy, except as expressly listed in What’s Covered Under the Plan or as provided in the Member Assistance Plan.

• Custodial care not rendered during a covered inpatient admission, including but not limited to non-medical home care, respite care, rest care, or similar services that primarily assist covered persons in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet. Also excluded except during a covered inpatient admission are preparation of special diets, supervision of medication that is 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.

• Educational services for remedial education or developmental therapy.

• Equipment or services for use in altering air quality or temperature.

• Elective or voluntary enhancement procedures, services, and medications provided to improve weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging or mental 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, including acne scars, regardless of whether Plan benefits were paid to treat the condition that caused the scars.

• Electrical continence aids, anal or urethral.

• Enteral feeding food supplement: The cost of outpatient enteral tube feedings or formula and supplies, except as expressly listed under What’s Covered Under the Plan.

• Examinations: Physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments conducted for purposes of medical research or to obtain or maintain a license of any type.

• Exercise equipment.

• Eyeglasses and contact Lenses: Provision or fitting of eyeglasses or contact lenses, except as expressly listed under What’s Covered Under the Plan.

• Eye services: Orthoptic, eye exercises, blepharoplasty, radial keratotomy, Lasik and other refractive eye surgery.

• Food or food supplements.

• Growth hormone, except as expressly listed under What’s Covered Under the Plan.

• Hair analysis, hair styling, wigs and hair transplants whether or not ordered by a physician.

• Home services to help meet personal, family or domestic needs.

• Health and athletic club membership: Any expenses of enrollment and membership in a health, athletic or similar club.

• Hearing services and supplies: Hearing aids and examinations for prescribing and fitting hearing aids, and hearing therapy.
• Household equipment and fixtures: Purchase or rental of household equipment, including 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.

• Home obstetrical delivery.

• Hypnotherapy.

• Hypnosis.

• Illegal activity: Injury or sickness resulting from participation in, or as a consequence of having participated in, any criminal activity or enterprise.

• Immunizations for travel or employment, except as expressly listed under What’s Covered Under the Plan.

• 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.

• Maintenance therapy.

• Massage therapy.

• 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 (USERRA), 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.

• Missed appointment charges or charges for time spent traveling.

• Naturopathic or holistic services.

• No charge to covered person: Services and supplies furnished to a covered person without charge, such as part of a study, grant or research program, free clinics, free government programs, court-ordered care, or that portion of any charge which would not be made except for the availability of benefits from the Plan.

• Non-emergency care when traveling outside the United States.

• Over-the-counter supplies and medications unless expressly listed under What’s Covered Under the Plan.

• Prescription drugs except as provided through the Prescription Drug Benefit.

• Private duty nursing services.

• Self-Injectable medications, except as covered in the Prescription Drug Benefit.

• Smoking cessation programs, except the Plan’s approved program covered as a listed preventive benefit.

• Third party liability: Services or supplies received to diagnose or treat any injury or sickness 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.

• Transportation for delivery of home health care.

• Transsexual surgery and associated charges.

• War: Injury or sickness 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 sickness), whether in peacetime or wartime and whether intended or accidental.

• Weight loss medications and procedures intended primarily for weight loss, unless treatment is medically necessary due to morbid obesity as defined by the National Institutes of Health (NIH).
Prior Authorization Requirements

The Plan specifies certain services and supplies for which prior authorization is required as a condition of coverage. Prior authorization, also called “utilization management,” is a determination made by the Plan before services are provided as to whether a proposed service is medically necessary. The Plan ordinarily bases this determination on advice received from medical professionals, who may be furnished by network sponsors or may be independent medical experts retained by the Plan.

Prior authorization confirms that a proposed service or supply is considered medically necessary for purposes of qualifying for Plan benefits. Prior authorization does not guarantee either coverage or availability of benefits. Prior authorization is not intended, and should not be used, as medical advice about the appropriate or advisable course of medical treatment, which remains the exclusive responsibility of the covered person and attending physician.

Services and Supplies Requiring Prior Authorization

The following is a summary of medical services and supplies for which prior authorization is required as a condition of coverage under the Platinum and Gold Benefit Schedules (see What’s Covered Under the Plan on page 21 for additional detail). The Plan also provides a summary of services requiring prior authorization at [www.carpdc.coventryhealthcare.com](http://www.carpdc.coventryhealthcare.com).

- Abortion
- Advanced radiology services
- Ambulance service by air and water, or transfers between facilities
- Breast pumps (hospital grade)
- Brachytherapy
- Chemotherapy and radiation therapy
- Clinical trials
- Cosmetic, plastic and related reconstructive surgery
- Dental procedures (when covered under the Medical Benefit)
- Dialysis
- Durable medical equipment
- Genetic testing and counseling
- Global obstetrical care
- Home health care services
- Hyperbaric treatment
- Inpatient hospital care, except maternity admission that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section
- Inpatient, residential, intensive outpatient and partial hospitalization treatment of mental and nervous disorders and substance abuse
- Mastectomy
- Medical complications
- Newborn inpatient care after discharge of mother
- Orthopedic devices over $500
- Outpatient diagnostic tests and therapeutic treatments
- Outpatient surgery
- Pain management injections
- PKU and similar inherited conditions — formula and food
- Proton beam therapy
- Prosthetic devices and braces over $10,000, and refitting or replacements
- CT scans, MRIs, MRAs, PET scans
- Sclerotherapy
- Sleep studies
- Skilled nursing facilities
- Sterilization, by outpatient vasectomy
- TMJ treatment — surgical or non-surgical
- Transplants (including stem cell and bone marrow transplants)
Prior Authorization Procedures

If you see a network provider for your care, your network provider will handle any prior authorization required by the Plan. You will not be denied any benefits if your network provider fails to request a prior authorization.

If you see an out-of-network provider for your care, you must ensure that prior authorization has been obtained as required by the Plan.

The Plan’s network sponsors will provide guidance regarding prior authorization steps. For prior authorizations for general medical care, contact Coventry Health Care. You may be directed to one of the Plan’s other network for certain authorizations, such as for mental health or substance abuse. Contact information for the Plan’s network sponsors can be found at the beginning of this Summary Plan Description.

For situations in which prior authorization is impossible, such as emergency admission to a hospital or emergency treatment of mental disorders or substance abuse, the request for prior authorization will be considered timely if made by the next business day following admission or treatment.

Prior authorization granted for a hospitalization will specify an approved level and description of care and initial length of stay. After the patient’s admission, an attending physician may request one or more extensions of the length of stay. Inpatient hospital care is not covered by the Plan after the expiration of the approved 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.

Failure to Obtain Required Prior Authorization

The Plan will pay no benefits for a service or supply if prior authorization is denied.

The Plan will deny a claim for benefits if a timely request was not made and granted for prior authorization of a service or supply obtained from an out-of-network provider. The exception to this policy is when circumstances make obtaining prior authorization impossible or could seriously jeopardize the life or health of the claimant, such as in cases of emergency.

If, within 60 days of such denial, the covered person provides evidence satisfactory to the Trustees of good cause for having failed to make a timely request, the Plan will conduct a retrospective review to determine whether the service or supply in question was medically necessary. The claim denial will stand as the Plan’s initial claim determination if the covered person fails to demonstrate good cause, 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 excused.

Medical Care Management

The Plan maintains medical care management programs designed to provide education, support and coordination services to members and dependents. Members may participate in these programs if they choose. There is no charge for participation, and no loss of benefits for electing not to participate.

High-Risk Pregnancy Care

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.

High-Risk 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 outcomes. Case managers may also assist with discharge planning from an inpatient stay.
The Plan’s Prescription Drug Benefit is provided automatically, without additional contributions or premium, to members in the active classification and members who are not eligible for Medicare in the non-active classification and their dependents. The Prescription Drug Benefit covers medically necessary prescription drugs, as well as certain preventive medications. There are two Prescription Benefit Schedules (just as there are two Medical Benefit schedules): the Platinum Schedule and the Gold Schedule, as set forth in the chart below.

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG SCHEDULE OF BENEFITS</th>
<th>HOW THE PLAN WORKS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Platinum Plan</td>
</tr>
<tr>
<td>RETAIL (Up to a 30-day supply per prescription)</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>Plan pays 90%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $50 maximum per prescription</em></td>
</tr>
<tr>
<td>Preferred brand-name</td>
<td>Plan pays 65%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $75 maximum per prescription</em></td>
</tr>
<tr>
<td>Non-preferred brand-name</td>
<td>Plan pays 60%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $125 maximum per prescription</em></td>
</tr>
<tr>
<td>Diabetes and insulin supplies</td>
<td>Plan pays 90%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $50 maximum per prescription</em></td>
</tr>
<tr>
<td>MAILORDER (Up to a 90-day supply per prescription)</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>Plan pays 90%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $100 maximum per prescription</em></td>
</tr>
<tr>
<td>Preferred brand-name</td>
<td>Plan pays 65%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $150 maximum per prescription</em></td>
</tr>
<tr>
<td>Non-preferred brand-name</td>
<td>Plan pays 60%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $250 maximum per prescription</em></td>
</tr>
<tr>
<td>Diabetes and insulin supplies</td>
<td>Plan pays 90%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $100 maximum per prescription</em></td>
</tr>
<tr>
<td>SPECIALTY MEDICATIONS</td>
<td></td>
</tr>
<tr>
<td>Preferred brand-name</td>
<td>Plan pays 65%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $150 maximum per prescription</em></td>
</tr>
<tr>
<td>Non-preferred brand-name</td>
<td>Plan pays 60%</td>
</tr>
<tr>
<td></td>
<td><em>Member pays $250 maximum per prescription</em></td>
</tr>
<tr>
<td>Drugs approved by FDA on or after 1/1/2013</td>
<td>Plan pays 50%</td>
</tr>
<tr>
<td></td>
<td><em>No per-prescription maximum for member</em></td>
</tr>
<tr>
<td>ANNUAL MAXIMUM</td>
<td></td>
</tr>
<tr>
<td>Family out-of-pocket maximum</td>
<td></td>
</tr>
</tbody>
</table>
Benefits are higher for generic drugs than for brand-name drugs, as shown in the chart on the page 36. Within the brand-name classification, benefits are higher for preferred drugs, which are those listed on the Plan’s formulary, than for non-preferred drugs. The Plan’s formulary is a list of generic and preferred brand-name medications that have been tested for quality and effectiveness. The Plan maintains an “open” formulary, in that it also provides coverage at a less generous level for drugs not specifically included in the formulary — the “non-preferred brand-name drugs.” The Plan uses the formulary recommended by Express Scripts, the Plan’s prescription drug network sponsor.

**Always consider generics:**

When you require medications, ask your physician about generic drugs. Generics are lower-priced equivalents of brand-name drugs. They’re approved by the U.S. Food and Drug Administration and have the same active ingredients as their brand-name equivalents. In some instances, generic medications are required under the Plan. With maintenance medications, there may not always be a generic equivalent to a brand-name drug, but there are often generic drugs in the same therapeutic classification that can effectively treat your condition. Please discuss these options with your physician. Your copay for brand-name drugs will be higher than it is for generic medications for both retail and home delivery.

**Covered Drugs**

Drugs are covered for benefits under the Platinum and Gold Schedules only if they are:

- Prescribed by a physician, in all cases;
- Legally required to be prescribed, except for certain medications available over-the-counter (OTC) without prescription that are expressly covered in the Plan;
- FDA-approved for the condition for which prescribed;
- Medically necessary, except as otherwise expressly stated in the Plan; and
- Obtained from an in-network provider, except in emergency situations 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 over-the-counter.

Compound medications are covered only if approved in advance under criteria established by Express Scripts, the Plan’s prescription drug network sponsor.

Compound drugs are prescription drugs consisting of two or more ingredients mixed to meet the unique needs of a particular patient — for example, a liquid medication in place of a pill for a patient who has difficulty swallowing, or a drug made without a specific ingredient to which a patient may be allergic. A request for approval of a compound medication must be submitted to Express Scripts, and must include the following details:

- Identification of all ingredients;
- Cost of each ingredient; and
- Supporting clinical evidence.

Compound medications that have a commercially available non-compound alternative are not covered. Approval of a compound drug applies only to ingredients as submitted.
Preventive Medications

The drugs, services and devices listed below are eligible for coverage under the Platinum and Gold Prescription Benefit Schedules as follows:

- Only if prescribed by a physician;
- Only if obtained from an in-network provider;
- Regardless of whether legally required to be prescribed; and
- Regardless of medical necessity, unless otherwise stated.

Preventive drugs, services and devices listed in this table are payable without cost sharing — they are covered at 100%, with no deductible or copayment.

The preventive drugs listed below are intended to conform to all of the following:

Recommendations of the United States preventive Services Task Force with rating of A or B; and

For women, infants, children and adolescents, guidelines supported by the Health Resources and Services Administration, all of which are referred to herein jointly as the “preventive recommendations.” (The list is amended from time to time to conform to future changes in the preventive recommendations.)

<table>
<thead>
<tr>
<th>Drug or Drug Category</th>
<th>Criteria for Coverage</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin prescribed to prevent cardiovascular events</td>
<td>Men age 45–79; Women age 55–79</td>
<td>Generic OTC products</td>
</tr>
<tr>
<td>Oral fluoride</td>
<td>Children 6 months of age to 6 years of age</td>
<td>Generic OTC &amp; Rx products</td>
</tr>
<tr>
<td>Folic acid</td>
<td>Women through age 50 years</td>
<td>Generic OTC &amp; Rx products</td>
</tr>
<tr>
<td>Iron supplements</td>
<td>Children age 6-12 months of age at risk for iron deficiency anemia</td>
<td>Generic OTC &amp; Rx Products</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Men and women age 18 and over who use tobacco products</td>
<td>Must be enrolled in Plan’s smoking cessation program; generic OTC &amp; Rx products</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>Men and women age 65 and over who are at increased risk for falls</td>
<td>Generic OTC &amp; Rx products</td>
</tr>
<tr>
<td>Bowel preparation for colonoscopy</td>
<td>Men and women age 49–76</td>
<td>Generic OTC and Rx products; fill limit 2 prescriptions per 365 days</td>
</tr>
<tr>
<td>Contraceptives (hormonal)</td>
<td>Women through age 50</td>
<td>Generic or single-source brand where generic unavailable; including oral, transdermal, intravaginal, injectable and implantable.</td>
</tr>
<tr>
<td>Contraceptives (barrier)</td>
<td>Women through age 50</td>
<td>Diaphragm and cervical cap</td>
</tr>
<tr>
<td>Emergency contraceptive</td>
<td>Women through age 50</td>
<td>Generic and Ella</td>
</tr>
</tbody>
</table>
Special Coverage Limitations

The Plan’s coverage of certain drugs and drug classes is subject to additional conditions, as described below.

Step Therapy

Under step therapy, a patient must first try to use a “first step” drug or treatment before a “second step” drug (or drug class) will be covered under the Plan. The second drug will be covered only if the patient does not have medically satisfactory results from a trial use of the first drug, or experiences adverse side effects to it. The drugs and drug classes subject to these terms are listed here.

Anti-Arthritic Oral Drugs
First step: A traditional non-steroidal anti-inflammatory agent (NSAID) such as Ibuprofen
Second step: COX-2 medications such as Celebrex

Anti-Arthritic Injectables
First step: Methotrexate or other disease-modifying anti-rheumatic drug (DMARD)
Second step: Enbrel or Humira

Anti-Hypertensives
First step: A diuretic
Second step: Any medication other than a diuretic, except as required by other medical conditions

Selective Serotonin Reuptake Inhibitors (SSRIs)
SSRIs prescribed for depression are not covered unless the patient has first tried a prescribed course of generic citalopram without medically satisfactory results.

Osteoporosis Treatments
Drugs prescribed for osteoporosis are not covered unless the patient has first tried a prescribed course of generic bisphosphonate without medically satisfactory results.

Nasal Steroids
Nasal steroids are not covered unless the patient has first tried a prescribed course of generic fluticasone or Nasonex without medically satisfactory results.

Angiotensin Receptor Blockers
Angiotensin receptor blockers prescribed for high blood pressure, heart and kidney conditions or stroke are not covered unless the patient has first tried a prescribed course of generic angiotensin receptor blocker without medically satisfactory results.

Supply and Dosage Limit Program
The Plan does not cover the drugs and drug classes listed below for quantities or doses in excess of the specified limits.

Antifungal Medications Prescribed for Nail Fungus
Coverage is limited to 90-day supply per lifetime, unless prior authorization is obtained for a medically necessary additional quantity.
Anti-Migraine Medications
Coverage is limited to dosages that do not exceed the following limits, unless prior authorization is obtained for a medically necessary higher dosage:

- Amerge: 1 mg and 2.5 mg — 9 tablets per 30 days regardless of strength
- Axert: 6.25 mg and 12.5 mg — 12 tablets per 30 days regardless of strength
- Frova: 2.5 mg — 12 tablets per 30 days
- Imitrex: 25 mg, 50 mg, and 100 mg — 9 tablets per 30 days regardless of strength
- Imitrex Nasal Spray: 12 units or 2 packages per 30 days
- Imitrex Injections: 12 injections or 6 kits per 30 days
- Maxalt: 5 mg and 10 mg — 12 tablets per 30 days regardless of strength
- Migranal Nasal Spray: 8 units or 2 kits per 30 days
- Zomig: 2.5 mg and 5 mg — 12 tablets per 30 days regardless of strength
- Replax: 20 mg, 40 mg, and 80 mg — 9 tablets per 30 days regardless of strength

Insomnia Medications
Coverage is limited to quantities and dosages that do not exceed the following limits, unless prior authorization is obtained for a medically necessary higher dosage:

- Ambien and Sonata: Maximum of 14 tablets per 30-day supply regardless of dosage, and maximum of 30-day supply per claim
- Lunesta and Rozerem: Maximum of 30 tablets per 30-day supply regardless of dosage, and maximum of 30-day supply per claim

Drug-Specific Limitations
When coverage of a drug or drug class is limited to generic drugs, coverage will be extended to a brand-name drug for no more than one year at a time if the attending physician presents clinical documentation demonstrating that the patient cannot tolerate the generic form, and if prior authorization is obtained for the brand-name drug.

Stomach (Gastric) Acid Reduction Proton Pump Inhibitors (PPI)
Only generic drugs are covered. A new prescription for PPI is limited to eight weeks of therapy, unless clinical documentation is provided supporting one of the following diagnoses for which continued therapy is medically necessary:

- Severe GERD
- Zollinger Ellison Syndrome
- Schatzki ring
- Barrett’s esophagus
- GI cancers
- Chronic erosive esophagitis

Cholesterol (Lipid) Lowering Drugs
Only generic drugs are covered, except Crestor 40 mg will also be covered for patients with excessively high cholesterol levels for which a dosage of 40 mg or more is medically necessary.

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 be ineffective, or to cause an adverse reaction in the patient.
Antipsychotics
Only generic drugs are covered, and for children under the age of five years, only with prior authorization. Brand-name drugs are covered only if the prescribing physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to be ineffective, or to cause an adverse reaction in the patient.

Attention Deficit (CNS Stimulants)
Only generic drugs are covered, and for patients 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-name drugs are covered only if the prescribing physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to be ineffective, or to cause an adverse reaction in the patient.

Pain Medications
- Products containing acetaminophen are covered only for prescribed cumulative daily dosage of 4 g 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 three days will be covered if prescribed during a visit to an emergency room or urgent care facility.

Suboxone
Covered only when prescribed for opioid dependence with accompanying physician’s treatment plan. Coverage is limited to one year.

Excluded Drugs
The Plan does not provide prescription drug benefits under the Platinum and Gold Schedules for any of the following:
- Non-sedating antihistamines (NSAs).
- Medications available over-the-counter without prescription, except as expressly noted in the Plan.
- Any drug if and after the patient has failed to comply with or complete the covered course of treatment prescribed for that drug.
- Drugs intended for use in a physician’s office or intended as samples.
- Immunization agents, biological serum, vaccines, or biologicals covered under the Medical Benefit.
- Experimental or investigative drugs.
- Drugs a covered person is eligible to receive without charge under any workers’ compensation law, or any municipal, state or federal program.
- Rogaine, Renova, Propecia, or any other medication prescribed for the treatment of hair loss.
- Zyban and other smoking cessation agents, such as gum, patches and nasal spray including Nicorette, Habitrol, Nicoderm, Nicotrol, and ProStep, except as may be provided as part of the Plan’s smoking cessation program through Coventry WellBeing and Trestle Tree.
- Weight-loss medications.
- Tri-Vi-Flor and other pediatric vitamins containing fluoride (except for children older than six months of age through five years old).
- Any dental products, including fluoride preparations and rinses such as Luride and Phos-Flur (except for children older than six months of age through five years old).
- Drugs used to enhance or improve fertility.
- Anabolic steroids, including Anadrol, Oxandrin, and Winstrol.
- Any drugs, services or devices that do not satisfy the general conditions of Platinum and Gold Coverage under the terms of the Plan.
- Drugs not FDA-approved for the condition for which prescribed.
Network Providers

The Plan generally pays prescription drug benefits only for drugs obtained from an in-network provider. Specialty prescriptions must be filled by the specialty network to be covered, except that a limited-distribution specialty drug may be obtained from the approved issuing pharmacy.

Express Scripts is the pharmacy benefit manager (PBM) and network sponsor for the retail network and home delivery (mail order) network. The specialty drug network is Diplomat Pharmacy. Contact information for Express Scripts and Diplomat Pharmacy can be found at the beginning of this Summary Plan Description.

As a limited exception to the in-network requirement, the Plan will cover a drug from an out-of-network provider in emergencies when an in-network provider is not reasonably accessible, as determined by the Trustees.

Retail Pharmacy Network

In general, the Plan covers up to a 30-day supply (other than maintenance or specialty drugs) obtained from a provider in the Express Scripts retail network.

In the case of maintenance drugs (as described below), up to two consecutive 30-day fills of a new prescription are covered in the retail network, after which further fills of the prescription are covered only when obtained in the home delivery network.

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.

Maintenance Medications by Home Delivery

Maintenance medications are those taken on a regular, recurring basis, prescribed to treat a chronic condition like high blood pressure, asthma, arthritis or heart disease. If you or your covered dependents use a maintenance medication, you may go to a retail pharmacy the first two times you fill the prescription, subject to the appropriate charge. If you need to fill the prescription a third time or more, you must use the home delivery network, subject to certain exceptions.

Home Delivery Network (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 from the home delivery network, except that 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, asthma and diabetes.

If it is difficult for you to use the home delivery network, for any of the reasons described below, the Plan may approve your continuing use of the retail network to purchase maintenance drugs that are generally covered only in the home delivery network. The possible circumstances that might be recognized by the Plan in granting this approval include:

- The patient is confined in a long-term care facility;
- The patient has demonstrated inability to use mail order due to physical or mental incapacity;
- The drug is out of stock in the home delivery network; or
- The cost of the drug is lower at the retail network than in the Home Delivery Network.
- The Trustees determine that the home delivery network is unable to supply the patient’s drug with reasonable reliability.
How to Order Home Delivery Prescriptions:

There are three ways to fill your prescriptions through the home delivery program:

► Complete a home delivery order form and send it, together with your original prescription (for up to a 90-day supply) and your copayment (contact Express Scripts Pharmacy Member Services at 800-939-2134 for correct dollar amount) to Express Scripts at the address printed on the form;

► Your physician may fax your prescription to Express Scripts Pharmacy at 800-837-0959; or

► Visit www.express-scripts.com and transfer any existing scripts from the retail pharmacy you currently use to Express Scripts for home delivery.

Allow at least 14 days from the date you submit your order for delivery. The home delivery form and the Express Scripts website detail how you can pay by credit card. Home delivery forms are available from the Carpenters’ Benefit Plans Office or online at www.carpdc.org/BenefitServices/Forms. Contact Express Scripts to check on your order, to verify the correct copayment for your prescription drug, and to answer any other questions you may have regarding the program or visit Express Scripts at www.express-scripts.com.

Specialty Drug Network

Drugs classified by the FDA as specialty drugs are covered under the Platinum and Gold Schedules only when obtained from the Diplomat Pharmacy, except that a limited distribution specialty 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, and hemophilia. All newly prescribed specialty drugs require prior authorization.

Under the Platinum and Gold Schedules, for a specialty drug approved by the FDA on and after January 1, 2013, the Plan’s coinsurance rate will be 50% unless the Trustees assign to such drug the preferred (65%) or non-preferred (60%) coinsurance rate.

The Plan follows the criteria of the Diplomat Pharmacy to identify specialty drugs that have a high risk of intolerance or serious adverse effects, thus warranting short-fill trials. The current list of such drugs is available at the Plan Office or on the Plan website at www.carpdc.org/BenefitServices or www.diplomat.is. A new prescription for such a specialty drug is covered only for a 15-day supply, for up to the first six fills, as recommended by the Diplomat Pharmacy criteria.

Prior Authorization Requirements

As in the case of services and supplies within the Medical Benefit, the Plan specifies certain drugs or quantities for which prior authorization is required as a condition of receiving any prescription drug benefit. Prior authorization, also called “utilization management,” is a determination made by the Plan before services are provided as to whether a proposed drug is medically necessary. The Plan ordinarily bases this determination on advice received from medical professionals, who may be furnished by network sponsors or may be independent medical experts retained by the Plan.

Prior authorization confirms that a proposed drug is considered medically necessary for purposes of qualifying for Plan benefits. Prior authorization does not guarantee either coverage or availability of benefits. Prior authorization is not intended, and should not be used, as medical advice about the
appropriate course of medical treatment, which remains the exclusive responsibility of the covered person and attending physician.

The Plan contracts for its prescription drug network sponsors to furnish prior authorization advice concerning a proposed drug. In-network providers are responsible for obtaining any required prior authorization for drugs they dispense. Because the Prescription Drug Benefit is generally limited to in-network providers, a covered person is not required to initiate a request for prior authorization except in the case of a drug administered in the course of emergency care when an in-network provider is not reasonably accessible.

In the case of such emergency care, the covered person or attending physician must request prior authorization by calling the Plan’s prescription drug network sponsor no later than the next business day. Prior authorization is satisfied only if certified by the network sponsor.

If a covered person fails to make a timely request for prior authorization of a drug obtained from a non-network provider, no benefits will be paid unless the covered person demonstrates good cause for the untimely request, is granted retrospective review by the Trustees, and establishes medical necessity to the Trustees’ satisfaction.

Either at the time of an initial benefit determination, or on retrospective review or appeal, the Plan may act upon prior authorization advice received from the network sponsor, or may request a second opinion from an independent professional source.

Amount of Benefit

For prescription drug coverage under the Platinum and Gold Schedules, the allowable amount for a prescription is the lesser of the full amount charged, or the uniform charge that the network provider has agreed to accept as a member of the network. No deductibles or copays are applicable.

When you purchase covered medications under the Plan, the Plan will pay the allowable amount multiplied by the coinsurance rate set forth in the Prescription Drug Schedule of Benefits (see page 36). You are responsible for the coinsurance share equal to the balance of the allowable amount for the prescription. However, the amount you are required to pay will not exceed the per-prescription maximum charges shown in the Schedule of Benefits.

When the combined amount of coinsurance payments you and your covered dependents make in a calendar year reaches the family annual out-of-pocket maximum, the Plan will pay 100% of charges for covered prescriptions for the remainder of the calendar year.
The Dental Benefit

Eligibility

The Plan’s Dental Benefit provides coverage for a comprehensive range of dental services and encourages preventive care. The Dental Benefit is provided automatically to members in the active classification and their dependents, without additional contributions or premiums.

The Dental Benefit is also available as optional coverage, at an additional premium, to members and dependents in the non-active classification, including members enrolled in the UHC Medicare Advantage Program and their dependents. The Dental Benefit may be elected at the time of initial enrollment in the non-active classification, or during an Open Enrollment period held October 1 through December 15 each year. If the Dental Benefit is dropped after having been elected, it may not be reinstated.

The Dental Benefit is self-funded by the Plan. The Plan has contracted with Delta Dental of Missouri to serve as network sponsor, to process dental claims, and to provide access to its dental networks. All necessary claims for dental benefits (whether from in-network or out-of-network providers) must be submitted directly to Delta Dental.

Covered Services

The Plan generally pays benefits only for dental procedures listed on the Plan’s Dental Fee Schedule, which is a supplement to this SPD. The Dental Fee Schedule lists, by type of service or procedure, the amounts that the Plan will recognize as its share of the cost for covered services. The Dental Fee Schedule is available on www.deltadentalmo.com/carpdc or www.carpdc.org/BenefitServices.

Procedures are covered only if they are:

- Performed by a licensed dentist (DDS or DMD), or by a licensed dental hygienist under the supervision of a dentist;
- Medically necessary, except if listed as “preventive;” and
- Not excluded under the general exclusions section below.
**Levels of Benefits**

**Network providers:** You can go to any dentist you choose, but you will generally pay less for your care and can avoid having to file claim forms when you use a Delta Dental network dentist rather than an out-of-network dentist.

There are two nationwide networks offered by Delta Dental and made available through Delta Dental of Missouri — the PPO network and the Premier network. Providers in both networks are named and updated on lists maintained at the Plan Office and on the Delta Dental website at [www.deltadentalmo.com/carpdc](http://www.deltadentalmo.com/carpdc). Note that your dental dollars will go furthest when you use a PPO dentist; the Plan’s Dental Fee Schedule provides higher benefits for PPO providers than for Premier or out-of-network providers. (For details, see the Coverage Examples on page 48.)

**Annual deductibles and maximums:** The annual dental deductible is the amount of covered dental expenses each covered person must pay each year before receiving dental benefits from the Plan. The annual maximum benefit payable is the most the Plan will pay in benefits each year for covered services. The annual deductible and maximum are detailed in the chart below.

<table>
<thead>
<tr>
<th></th>
<th>Delta Dental PPO</th>
<th>Delta Dental Premier</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible Waived for orthodontia</strong></td>
<td>$25 per person Waived for preventive care</td>
<td>$25 per person</td>
<td>$25 per person</td>
</tr>
<tr>
<td><strong>Annual Maximum Benefit</strong>*</td>
<td></td>
<td>$2,000 per person</td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit for Orthodontia</strong></td>
<td></td>
<td>$1,500 per person</td>
<td></td>
</tr>
</tbody>
</table>

*Does not apply to dependent children under age 19 for preventive services obtained from a Delta Dental PPO provider, or to eligible dental services provided under the Special Accident Benefit.

**Does not apply to medically necessary orthodontia obtained from a Delta Dental PPO provider or to orthodontia covered under the Special Accident Benefit (with prior authorization).**

As listed in the chart above, the deductible is the first $25 of covered expenses for each covered person each year (except orthodontia). The deductible is waived for preventive services obtained from a Delta Dental PPO provider.

The annual maximum benefit payable for dental services each year (except orthodontia) is $2,000 per covered person. This limit does not apply to dependent children before their 19th birthday for preventive dental services obtained from a Delta Dental PPO provider.

The lifetime maximum benefit for covered orthodontia expenses incurred by a covered person is $1,500. Medically necessary orthodontia obtained from a Delta Dental PPO provider covered under the Special Accident Benefit, is not subject to the orthodontia lifetime maximum. Medically necessary orthodontia must be reviewed and approved in advance by the network sponsor.
Special Accident Benefit

The Plan provides benefits apart from the Dental Fee Schedule for dental treatment of accidental injuries to a tooth, teeth, jaw or restorations. For purposes of Plan benefits, an accidental injury is a physical injury not related to the normal function of the tooth or teeth. Except for emergency services, these services are covered only with prior authorization. Benefits obtained in either the PPO or Premier network will be paid at 90% of the allowable amount. Out-of-network services are subject to the reasonable and customary limit, and will be paid at 50% of the allowable amount. Services approved and paid under this benefit will not be subject to the annual maximum but are subject to the annual individual dental deductible.

Determination of Benefit Amounts

Upon receiving a claim for services, the Plan will pay the lesser of the billed charge, the amount an in-network provider has agreed to accept as a member of the network, or the fee specified in the Plan’s Dental Fee Schedule. This payment will be reduced by any unpaid portion of your annual deductible, if applicable. (For details, see the Coverage Examples on page 48.)

Plan benefits payable are also subject to the following limitations:

- No benefit will be paid in excess of an applicable annual or lifetime maximum benefit unless specifically noted;
- No benefit will be paid for dental services performed outside a dentist’s office if a required prior authorization was not obtained;
- No benefit will be paid under the Special Accident Benefit if prior authorization was not obtained;
- If there are two or more possible methods of treating a particular dental condition, no benefit will be paid in excess of the reasonable and customary charges for the covered services and supplies customarily employed nationwide in the treatment of that condition, and recognized as appropriate in accordance with broadly accepted nationwide standards of dental practice, taking into account the oral condition of the covered person; and
- No benefit will be paid for services and supplies specifically excluded under the Plan, as listed below.

The reasonable and customary allowable amount applied to out-of-network claims is equal to the allowable amount under the Delta Dental PPO contracted rate. There are no copays, coinsurance charges, or out-of-pocket limits applicable to the services allowed on the Dental Fee Schedule. You are responsible for the difference between the billed charge and the Plan benefits payable when using network providers. If you use out-of-network providers, you are responsible for the difference between the billed charge and the Plan benefits payable. Although deductibles and maximum limits are the same for Premier network providers and out-of-network providers, Premier network providers will not bill an amount in excess of the charge the provider has agreed to accept as a member of the network. By contrast, out-of-network providers are not limited in the amount they may charge.
Coverage Examples

When you see Delta Dental network dentists — and particularly, PPO dentists — rather than out-of-network dentists, you always limit your out-of-pocket costs. Providers contracted with Delta Dental’s PPO networks have agreed to accept maximum allowable payments from the Plan as payment in full for some covered dental services. When you see a PPO or a Premier in-network provider, after you have met any applicable annual deductible, you will pay no more than the difference between the amount shown in the Plan’s Dental Fee Schedule and the amount that the in-network provider has agreed to accept as a member of the Delta Dental network. Your savings are greatest with PPO providers because the Plan provides higher benefits for PPO providers than Premier providers.

Out-of-network providers, by contrast with network providers, do not have agreements with Delta Dental regarding their service fees. The difference between what the Plan will pay for services and the dentist’s full charge is likely to be greater than with network dentists, and will be your full responsibility.

Here are two illustrations of how you can save money using Delta Dental network providers.

EXAMPLE 1: Preventive Services

<table>
<thead>
<tr>
<th>Service: Periodic oral exam, 2 intraoral X-rays and adult prophylaxis</th>
<th>Delta Dental PPO Dentist</th>
<th>Delta Dental Premier Dentist</th>
<th>Out-of-Network Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for service: Hypothetical dentist billed charge</td>
<td>$195.00</td>
<td>$195.00</td>
<td>$195.00</td>
</tr>
<tr>
<td>Maximum allowable charge by Delta Dental: Amount the contracted provider has agreed to accept as payment in full for the stated services</td>
<td>$123.00</td>
<td>$180.00</td>
<td>N/A</td>
</tr>
<tr>
<td>Network saves member: Amount not chargeable by providers in the PPO and Premier networks</td>
<td>$72.00</td>
<td>$15.00</td>
<td>$0</td>
</tr>
<tr>
<td>Carpenters’ Fee Schedule: The Plan’s share of the allowed charge</td>
<td>$123.00</td>
<td>$92.98</td>
<td>$92.98</td>
</tr>
<tr>
<td>Member pays: Your responsibility is the maximum allowable charge less the amount in the Carpenters’ Fee Schedule</td>
<td>$0.00</td>
<td>$87.02</td>
<td>$102.02</td>
</tr>
</tbody>
</table>
**EXAMPLE 2: Restorative Services**

<table>
<thead>
<tr>
<th>Service: Amalgam one surface, resin composite one surface, extraction</th>
<th>Delta Dental PPO Dentist</th>
<th>Delta Dental Premier Dentist</th>
<th>Out-of-Network Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fee for service:</strong> Hypothetical dentist billed charge</td>
<td>$495.00</td>
<td>$495.00</td>
<td>$495.00</td>
</tr>
<tr>
<td><strong>Maximum allowable charge by Delta Dental:</strong> Amount the contracted provider has agreed to accept as payment in full for the stated services</td>
<td>$247.00</td>
<td>$450.00</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Network saves member:</strong> Amount not chargeable by providers in the PPO and Premier networks</td>
<td>$248.00</td>
<td>$45.00</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Carpenters’ Fee Schedule:</strong> The Plan’s share of the allowed charge</td>
<td>$95.00</td>
<td>$76.00</td>
<td>$76.00</td>
</tr>
<tr>
<td><strong>Member pays:</strong> Your responsibility is the maximum allowable charge less the amount in the Carpenters’ Fee Schedule</td>
<td><strong>$152.00</strong></td>
<td><strong>$374.00</strong></td>
<td><strong>$419.00</strong></td>
</tr>
</tbody>
</table>

**Summary**

The bottom-line comparisons in these examples show you how the PPO network gives you best value for your money. In addition, the “Network saves member” lines show clearly that your dollars go further when you use Delta Dental network providers—especially PPO providers.
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 the medical necessity of both the facility and the procedures is established in advance by prior authorization.

The Plan contracts for Delta Dental to furnish prior authorization advice for the Dental Benefit. In-network dentists will generally request prior authorization on your behalf. However, you are responsible for ensuring that required prior authorization is obtained for services provided, particularly when you see out-of-network providers. Requests for prior authorization must be submitted to Delta Dental.

Note that prior authorization alone does not guarantee either coverage or availability of benefits.

There is no prior authorization requirement for other services and supplies performed inside a dentist’s office. You may, however, obtain a predetermination of Plan benefits payable for a proposed course of treatment for which expected charges exceed $300 if the dentist’s treatment program is submitted to Delta Dental before services are performed. The submission should include details of the condition of the patient’s mouth, the dentist’s proposed services, and the charges for those services. Delta Dental will notify the patient and dentist of its determination of medical necessity, any alternative courses of treatment that could affect the benefits payable, and the estimated benefits payable based on the planned course of treatment.

Limitations and Exclusions

No dental benefits will be paid for or in connection with:

- Services or supplies for which the covered person would normally incur no charge in the absence of Plan coverage, such as care rendered by a dentist to a member of his family or the family of his spouse.
- Services or supplies arising out of the course of any occupation or employment for compensation, profit or gain, or for which the covered person may be entitled to benefits under any applicable workers’ compensation act, occupational disease policy or similar law (including settlement of a claim).
- Charges for services neither specified in the Dental Fee Schedule, nor covered under the Special Accident Benefit. However, if a charge for a particular service is not included in the Dental Fee Schedule, but the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, a charge will be considered to have been incurred for a service listed in the Schedule that would have produced a professionally satisfactory result.
- 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.
- Services or supplies performed for cosmetic purposes or to correct congenital malformations.
- Charges that are not reasonably necessary or customarily provided for the covered person’s dental condition.
- 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.
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 satisfactorily, a replacement will be covered only once in five years, provided that the five-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.

- Services or supplies related to temporomandibular joint (TMJ) dysfunction.
- Duplication or replacement of lost or stolen appliances.
- Diseases contracted or injuries or conditions sustained as a result of any act of war.
- Denture adjustments for the first six months after the dentures are initially received.
- Repair or replacement of an orthodontic appliance.
- 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.
- Analgesia, including nitrous oxide, other than local.
- Duplication of radiographs or temporary appliances.
- The portion of a charge for a listed service in excess of the fixed schedule amount detailed in the Dental Fee Schedule.
- Any dental services to the extent that benefits are payable under the Plan’s Medical Benefit.
- 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.
- Oral hygiene and dietary instruction or plaque control programs.
- Failure to keep a scheduled appointment with the dentist.
- Completion of claim forms.

- Charges for personalization or characterization of dentures.
- Charges for services or supplies that are 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. Charges for medications, infection control or medical waste disposal.
- Diagnosis and treatment of an injury or sickness resulting from participation in, or as a consequence of having participated in, any criminal activity or enterprise.
- Benefits for routine examinations and cleanings are limited to two per calendar year. A PPO network provider must be used for routine exams and cleanings in order for no cost share Preventive benefit to apply.
- Services or supplies received as a result of any injury or sickness 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.
- Charges for fluoride or sealants are limited to dependents prior to their 19th birthday.
- 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.
- Endodontic (root canal) treatment on the same tooth is covered only once in a two-year period.
- Charges for replacement of filling restorations are only covered once in a 24-month period, unless the damage to that tooth was caused by accidental injury.
- 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.
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). If alternative treatment plans are available, benefits are limited to the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as composite resin filling on molar teeth, in which case the benefits are based on the allowed amount for an amalgam (silver) filling; or services such as implants, in which case the benefits may be based on the allowed amount for a fixed bridge or removable partial denture.

Sealants are limited to caries-free occlusal surfaces of the first and second permanent molars.

All rules regarding coordination of benefits, definitions, filing limits and other limitations applicable to the medical plan are also applicable to the dental plan.

Claims for Dental Benefits

When you see a Delta Dental provider, he or she will generally file claims on your behalf. If you see an out-of-network provider, you may have to pay for your care directly to the provider and file a claim for reimbursement.

In either case, claims must be filed within 365 days from the day in which services were rendered to be eligible for Plan benefits. The Plan will not pay claims submitted after this period. If a claim is denied due to a PPO or Premier network provider’s failure to make timely submission, the covered person will not be liable to such provider for the amount which would have been payable by the Plan, provided the covered person advised the provider of eligibility for Plan benefits at the time of treatment. A covered person who obtains services and supplies from an out-of-network provider is responsible for filing a timely claim for reimbursement with Delta Dental.
The Vision Benefit

Eligibility

The vision benefit is designed to provide assistance for members and eligible dependents who need eyeglasses or contact lenses to improve their vision. This benefit is provided automatically, without additional contributions or premiums, to eligible members and dependents not enrolled in the UHC Medicare Advantage Program.

The Plan has access to the VSP comprehensive network of vision providers. VSP provides discounted rates on vision services and equipment when you use its network. All claims for vision services (whether from in-network or out-of-network providers) must be submitted directly to VSP.

Levels of Benefits

Members can receive covered services and supplies from in-network or out-of-network providers. But as shown in the chart below, you save money by going to VSP providers. VSP providers are named and updated on a list maintained at the Plan Office and on the VSP website at www.vsp.com. You can contact the Benefit Office for a copy of this list.

There are no deductibles, coinsurance rates or out-of-pocket limits for vision benefits. You are responsible for the portion of a billed charge in excess of the Plan benefits payable. VSP providers may not bill an amount greater than the uniform charge the provider has agreed to accept as a member of the VSP network. By contrast, out-of-network providers are not limited in the amount they may charge.

The frequency limitation is the number of months that must elapse after you receive a covered service or supply before the same service or supply is covered again. A copay is the amount you pay the provider when you receive service, for a listed service or supply from an in-network (VSP) provider. Out-of-network providers require full payment at the time of service.
### Covered Services and Supplies

The services and supplies listed in the schedule above are covered only if performed by a licensed optometrist, ophthalmologist, or dispensing optician. Covered eye exams include an evaluation of visual function and prescription of corrective lenses, if needed.

#### Routine Eye Examination

One routine eye exam is covered every 12 months, including an evaluation of visual function and prescription of corrective lenses if needed.
Lenses and Frames

Eyeglass lenses and frames are covered (subject to the applicable frequency limitation) provided that benefits have not been paid for contact lenses obtained during the preceding 12 months.

The “VSP Provider Maximum Benefit” for lenses noted in the schedule above is for standard lenses as defined by VSP. If you or your dependent elect to obtain non-standard lenses from a VSP provider, including but not limited to those with any of the following features, you will be required to pay the extra cost over the scheduled amount for standard lenses for the following equipment and services:

- Optional cosmetic processes;
- Anti-reflective, color, mirror or scratch coating;
- Blended, cosmetic, laminated, oversized and progressive multifocal lenses;
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2; or
- UV (ultraviolet) protected lenses.
- The same rule applies to related 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; and
  - Progress or follow-up work as necessary.

Any charges by an out-of-network provider for such services are included in the Plan’s maximum benefit for lenses and frames.

Contact Lenses

Contact lenses are covered (subject to the applicable frequency limit) provided that benefits have not been paid for eyeglass lenses or frames obtained during the preceding 12 months.

Contact lenses obtained from VSP include suitability evaluation and fitting. Any charges by an out-of-network provider for such services are included in the amount subject to the Plan’s maximum benefit for contact lenses.

The “VSP Provider Maximum Benefit” for medically necessary contact lenses noted in the schedule above is for standard contact lenses as defined by VSP. Contacts will be considered medically necessary only in one or more of the following situations, and only if pre-authorized by VSP:

- Following cataract surgery;
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- With anisometropia (unequal refraction in the eyes); or
- With keratoconus (corneal protrusion).

Additional Discounts

You and your dependents are entitled to receive a 20% discount toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP network provider. “Additional pair” means any complete pair of prescription glasses that is not covered under this Plan.

Also, you and your dependents are entitled to receive a 15% discount off a VSP network provider’s professional fees for contact lens evaluations and fittings that are not covered under this Plan. Discounts are applied to the provider’s usual and customary charge for such services. The discount is only available within 12 months after a covered eye examination. This discount does not apply to contact lens materials, which are provided at the reasonable and customary charge.
Determination of Benefit Amounts

Upon receiving a claim for services and supplies covered under the Vision Benefit and furnished by an in-network (VSP) provider, the Plan will pay the lesser of the billed charge or the applicable network scheduled amount, in either case reduced by any required copayment. If the services or supplies were furnished by an out-of-network provider, the Plan will pay the lesser of the billed charge or the maximum benefit amount set forth in the schedule, in either case reduced by any required copayment.

A covered person must pay in full the amount due an out-of-network provider for covered services and supplies, and file a claim with VSP for reimbursement from Plan benefits.

General Exclusions

No vision benefits will be paid for or in connection with:

- 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.
- 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.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except in compliance with applicable frequency limitations.
- Medical or surgical treatment of the eyes.
- Any eye examination or corrective eyewear, not otherwise covered by the Plan, required by an employer as a condition of employment.
- Experimental or investigative services or supplies.
- Drugs or medications.
- Corrective vision treatments such as RK, PRK LASIK and Custom LASIK.
- Care, services or supplies received as a result of any injury or sickness sustained due to the act or omission of a third party, unless the covered person has fully complied with the reimbursement or subrogation provisions of this Plan.
- Any vision services to the extent that benefits are payable under the Medical Benefit of this Plan.
- Costs for services and supplies in excess of Plan maximum benefits.

Special Low Vision Benefit

In addition to the benefits described above, the Plan offers a special low vision benefit program through VSP. If an eye examination performed by a VSP provider or non-VSP provider indicates that you or your dependent have a severe visual problem that is not correctable with regular lenses, you may submit a request to VSP for approval of coverage in the low vision program. Requests for pre-approval of low vision benefits must be directed to VSP Member Services at 800-877-7195 or on the VSP website at www.vsp.com.

If the request is approved, you may obtain a complete low vision analysis that includes a comprehensive exam of visual functions and prescription of corrective eyewear or vision aids as needed. If a VSP provider performs the low vision analysis, a $10 copayment applies and the remainder is paid in full by the Plan. If a non-VSP Provider performs the low vision analysis, the benefit is the lesser of the amount charged or $125. If the low vision analysis includes a prescription for additional therapy, corrective eyewear or vision aids, the Plan will pay an additional benefit for the prescribed items at a coinsurance rate of 75% of the lesser of the charged amount or the amount authorized by VSP, regardless of whether received by a VSP provider or an out-of-network provider. You must pay the balance of the provider’s charge.

The maximum aggregate benefit amount payable by the Plan under the special low vision benefit is $1,000 toward all covered charges incurred during each successive period of 24 months, beginning when the first such covered charge is incurred.

Claims for Vision Benefits

Claims must be filed within 365 days from the day in which services were rendered to be eligible for Plan benefits. The Plan will not pay claims submitted after this period. If a claim is denied due to a VSP provider’s failure to make timely submission, the covered person will not be liable to such provider for the amount which would have been payable by the Plan, provided the covered person advised the provider of eligibility for Plan benefits at the time of treatment. A covered person who obtains services and supplies from an out-of-network provider is responsible for filing a timely claim for reimbursement with VSP.
If you are a member in the active classification and unable to work due to a period of disability, the Plan provides a short-term benefit to protect a portion of your income.

**Eligibility**

If you are in the active classification and become temporarily disabled because of a non-occupational accident or sickness while you are eligible for medical benefits under the Plan, you are eligible for the Weekly Accident and Sickness Benefit.

For purposes of this benefit, “disabled” means that you are prevented from engaging in gainful employment, due solely to sickness or injury. In addition:

- You must be under the direct care of a physician, other than a chiropractor, who certifies your disability and states your expected return to work date.
- The treating physician must notify the Plan of any changes to the expected return-to-work date. The physician may also be required to document any determinations of continued disability.
- If your disability is caused by an accident, you must provide the Plan with complete details of time, place and circumstances of the accident.

**Benefits Payable**

The Weekly Accident and Sickness Benefit pays $300 per week, for up to 26 weeks, and begin as follows:

<table>
<thead>
<tr>
<th>In case of</th>
<th>Benefits begin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability due to accident, hospital confinement or outpatient surgery</td>
<td>First day of disability</td>
</tr>
<tr>
<td>Disability due to sickness, not involving hospital confinement or outpatient surgery</td>
<td>Eighth day after onset of disability</td>
</tr>
</tbody>
</table>

The benefit for each day of a partial week of disability is one-seventh of the weekly benefit calculated on a maximum seven-day work period.

If you return to work for less than 80 hours of work and become disabled again for the same or a related condition that caused the previous disability, your disability benefits will pick up where they left off before you returned to work. The combined benefit duration will not exceed 26 weeks.

If you return to work and become disabled again for a new and unrelated cause, at least eight hours of work must separate the two diagnoses in order for you to qualify for up to 26 weeks of benefits for the new disability.

Hours received and paid for as a result of picket duty do not qualify as credit hours for this purpose. Benefits terminate on the earliest of the last day of the member’s disability, the termination of coverage under the Plan, or after 26 weeks of disability benefits have been paid.

The Plan will deduct from Weekly Accident and Sickness benefits the amount of required FICA contributions, and will issue to the member an annual Form W-2 reporting the amount paid under this benefit for the calendar year.

**Exclusions**

No benefits are payable under the Plan for:

- Any day of disability on which a member is eligible for, or receiving, compensation from the member’s employer, or workers’ compensation benefits, even if occupational and non-occupational disabilities are unrelated.
- Disabilities resulting from any injury or sickness due to the act or omission of a third party, unless the member has fully complied with the reimbursement and subrogation provisions of this Plan.
- Periods that exceed accepted standards of disability, unless properly documented by the treating physician.
- Any day prior to or after the period when a member was under treatment, and was certified as disabled by an attending physician, even if the sickness or illness may have been present.
- Any day on which the Trustees determine that a member is not disabled, though certified as such by a physician.
- Disability resulting from any injury or sickness for which no medical benefits are payable.
- Any member covered under COBRA.
Life Insurance

The Plan provides Life and Accidental Death and Dismemberment (AD&D) benefits under policies insured by the Metropolitan Life Insurance Company (MetLife), a commercial insurance company. The terms and conditions of the benefits are as stated in the policies. The description provided here is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policies issued by MetLife, the terms of the policies will prevail. You may examine the policy documents at the Plan Office. All claim forms needed to file for benefits under the life insurance and AD&D policies can be obtained from the Plan Office.

Eligibility for Life and AD&D Benefits

You are eligible for Life Insurance and AD&D benefits if you are member and are eligible for medical benefits in the Plan or are enrolled in the UHC Medicare Advantage Program. (The exception is that members in the non-active classification who are covered under the reinstatement provisions of this Plan are not eligible for Life Insurance and AD&D benefits.)

A dependent who dies while eligible for medical benefits or while enrolled in the UHC Medicare Advantage Program is eligible for Life Insurance, but not AD&D benefits. Exceptions to this rule are the following dependents, who are not eligible for either Life Insurance or AD&D benefits:

- An individual who lived outside the United States or Canada at the time of death;
- A stillborn or unborn child;
- An individual in whom the insurance company determines that the related member had no insurable interest; or
- A dependent in the non-active classification who is covered under the reinstatement provisions of this Plan.

No person is entitled to additional benefit amounts by virtue of being the dependent of more than one member.

Level of Death Benefits

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance on life of member</td>
<td>$8,000</td>
</tr>
<tr>
<td>Insurance on life of eligible dependent</td>
<td>$2,000</td>
</tr>
<tr>
<td>AD&amp;D death benefit (members only)</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

The Life Insurance benefit is payable on account of death from any cause. The death benefit under the AD&D policy is payable only for accidental death. The AD&D death benefit, when payable under the terms of the AD&D policy, is payable in addition to the Life Insurance benefit. Benefits payable will not exceed the applicable amount shown in the chart above, except for interest that may become payable after death under the terms of the policy.

Death Beneficiary

The proceeds payable under the Life Insurance and AD&D policies on account of the death of a member will be paid to the member’s designated beneficiary.

Your designated beneficiary is a person you designate in writing, on the appropriate form filed in the Plan Office. If you name more than one beneficiary, the proceeds will be distributed equally to them unless you have directed otherwise. If a named beneficiary dies before you, that beneficiary’s interest will end, and will be shared equally by any remaining beneficiaries.

If your most recent beneficiary form filed at the Plan Office at the time of death names a former spouse — whose marriage was terminated by divorce or annulment after the form was filed — your death benefit will be paid as if the former spouse had died before you.

In the event there is no surviving designated beneficiary, or in the event there is no beneficiary designation on file in the Plan office, the death benefit will be paid as follows:

- To the member’s surviving spouse.
- If there is no surviving spouse, to the member’s surviving child or children, equally.
- If there are no surviving children, to the member’s surviving parents, equally.
● If there are no surviving parents, to the member’s siblings, equally.

● If there are no surviving siblings, to the member’s estate.

You may designate or change a beneficiary at any time by signing and dating a new beneficiary form. Any designation or change will be effective as of the date you signed the form, even if the Plan receives the new designation at a later date, and whether or not you are living at the time the Plan receives the change, 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 member or, after the member’s death, to the member’s personal representative or the designated beneficiary when properly identified.

Proceeds payable under the Life Insurance policy as benefits on account of the death of a dependent will be paid to the related member, 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.

Extended Life Insurance (Members Only)

If you are a member and you become totally disabled before age 60 while eligible for Life Insurance benefits and if your eligibility for Life Insurance benefits would otherwise end, the Life Insurance benefit in effect on the date your eligibility would otherwise end will nevertheless be paid at your death, provided you:

● Remain continuously totally disabled,

● Submit written proof of the uninterrupted total disability to the insurance company as follows:
  ▶ The first such proof must be received within 12 months after the date you cease active work. If you die during this 12-month period, the insurance company must receive proof not more than 12 months after the date of death.
  ▶ Thereafter, whenever the insurance company requests proof of continuing total disability.

● Submit to medical examination by a physician selected by the insurance company whenever required by the insurance company,

● Do not establish a claim under the conversion privilege (see below), and

● Surrender to the insurance company any policy of personal insurance issued on your 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 that because of a sickness or injury the member cannot do the important duties of the member’s job or any other job for which the member is fit by education, training, or experience.

Life Insurance Conversion Privilege (Members and Dependents)

If your or a dependent’s Life Insurance coverage under the Plan ends because of termination of eligibility, you or your dependent may convert the coverage to an individual policy of life insurance making application to the insurance company.

Application for an individual policy must be made within 31 days of the date coverage under the Plan ends. If you or your dependent dies within the 31 day period, a death benefit will be paid to the decedent’s beneficiary in an amount equal to that which you or your dependent was entitled to convert, whether or not application had been made.

Dismemberment Benefits Under the AD&D Policy

If you sustain an accidental loss of limb or sight, you will be entitled to a benefit under the terms of the AD&D policy that is a percentage of the AD&D death benefit, as shown in the following chart:

<table>
<thead>
<tr>
<th>FOR LOSS OF</th>
<th>THE AD&amp;D BENEFIT IS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>One hand, one foot or the sight of one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Both hands, both feet, sight of both eyes or any combination of two or more of the above losses</td>
<td>100%</td>
</tr>
</tbody>
</table>

The loss of a hand or foot means severance at or above the wrist or ankle joint. Loss of sight means total and irrecoverable loss. The maximum benefit payable for all losses resulting from one accident is 100% of the death benefit. Benefits are payable only for losses that are the direct result of an accident and that occur within 90 days following the accident.
Limitations on AD&D Benefits

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

- Physical illness, diagnosis or treatment for the illness;
- An infection, unless it is caused:
  - by an external or internal wound which was sustained in an accident; or
  - by the accidental ingestion of a poisonous food or substance; or
- Suicide or attempted suicide while sane;
- Injuring oneself on purpose;
- The use of any drug or medicine unless taken on advice of and consistently with the instructions of a doctor;
- A war or war-like action in time of peace, including terrorist acts; or
- Committing or trying to commit a felony or being engaged in an illegal occupation.

A member may obtain a complete copy of the AD&D Insurance certificate by contacting the Plan Office.

Safety Training

The Plan will provide without charge, to all persons eligible for Safety Enhancement benefits, the safety training course known as the “10-hour OSHA course.”

Upon completion of the 10-hour OSHA course, the Plan will provide eight hours of approved safety training per year, without charge, to all active members, to satisfy requirements of the Carpenters’ District Council of Greater St. Louis and Vicinity (CDC).

Approved safety training courses are listed on the Plan’s website. If you are a member, you may access your member training records from the website by logging in to your account at www.carpdc.org.

The Safety Training Program is administered by this Plan. Questions regarding class schedules or how to sign up may be directed to the Safety Training Department at 314-644-4802, press 3 or toll-free at 877-232-3863; press 3 for Employer Services. In addition, courses and school links can be found from the home page of www.carpdc.org under the “Skill Advancement” menu.

Substance Abuse Testing

Under the Carpenters’ District Council Drug and Alcohol Testing Program, all employees of contractors signatory to collective bargaining agreements of the CDC are subject to the testing policy, which specifies the following testing circumstances:

- Pre-employment testing;
- Reasonable suspicion testing;
- Post-accident/incident testing; and
- Random testing.

The Plan will provide testing services without charge, if you are:

- An employee covered by a collective bargaining agreement between an employer and the Carpenters’ District Council of Greater St. Louis and Vicinity (CDC);
- An employee of the CDC;
- An employee of the Carpenters’ Benefit Office; or
- An employee of the Carpenters’ Joint Apprenticeship Fund of St. Louis.
Services provided include testing for the presence in blood or urine of alcohol or controlled substances, under the procedures approved by the Trustees and modified from time to time.

The objective of this testing program is to improve safety, productivity and morale on all construction sites and to eliminate duplicate and redundant testing for members.

The Trustees have contracted with PCS Drug Screening to perform testing for this program. The locations and hours of operation of PCS facilities are:

<table>
<thead>
<tr>
<th>PCS Drug Screening, LLC — Cape Office</th>
<th>PCS Drug Screening, LLC — St. Louis</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Doctors’ Park</td>
<td>8300 Valcour Ave.</td>
</tr>
<tr>
<td>Cape Girardeau, MO 63703</td>
<td>St Louis, MO 63123</td>
</tr>
<tr>
<td>Toll Free: 800-329-2660</td>
<td>Phone: 314-752-1100</td>
</tr>
<tr>
<td>Phone: 573-334-4788</td>
<td>Fax: 314-752-4100</td>
</tr>
<tr>
<td>Fax: 573-332-1593</td>
<td>Hours: Mon., Wed., Thu., Fri., 7 a.m.–4 p.m.;</td>
</tr>
<tr>
<td>Hours: Mon.–Fri., 8:30 a.m.–4:30 p.m.</td>
<td>Tue., 7 a.m.–6 p.m</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PCS Drug Screening, LLC — Belleville</th>
<th>PCS Drug Screening, LLC — Kansas City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Illinois Training School</td>
<td>Kansas City District Council</td>
</tr>
<tr>
<td>2290 South Illinois St.</td>
<td>105 W. 12th Ave.</td>
</tr>
<tr>
<td>Belleville, IL 62220</td>
<td>North Kansas City, MO 64116</td>
</tr>
<tr>
<td>Phone: 618-222-9880</td>
<td>Effective August 1, 2015:</td>
</tr>
<tr>
<td>Fax: 618-222-9883</td>
<td>Kansas City District Council</td>
</tr>
<tr>
<td>Hrs: Mon., 7 a.m.–4 p.m.; Tue., 1 p.m.–5 p.m.;</td>
<td>8955 E. 38th Terrace</td>
</tr>
<tr>
<td>Wed.–Fri., 12 p.m.–4 p.m.</td>
<td>Kansas City, MO 64129</td>
</tr>
</tbody>
</table>

Additional information is available in the Drug Testing and Safety Training policy and procedure document available at the Plan Office.
A claim is a request for benefits under the Plan made by or on behalf of a covered person who has received covered services or supplies (a “claimant”). A claim will be determined initially by the Plan’s representatives. A claimant who is dissatisfied with the initial claim determination may file an internal appeal, which will be decided by the Plan’s Board of Trustees or their designee. In addition, a claimant will have opportunity to seek independent, external review of an adverse benefit determination made by the Plan.

For purposes of this section, an “adverse benefit determination” is a denial, reduction or termination of, or failure to provide or make payment for, a benefit, or any rescission of coverage, whether or not based on a determination of eligibility or application of any utilization review, including failure to cover a service or supply for which benefits are otherwise provided because it is experimental, investigative or not medically necessary. A “final internal adverse benefit determination” is an adverse benefit determination that has been upheld at completion or exhaustion of the Plan’s internal appeal process. A “final external review decision” is the decision rendered by an Independent Review Organization (IRO) at the conclusion of an external review.

To receive benefits under the Plan, a claimant must follow the procedures set forth below for the applicable benefit. The claimant has the right to receive free of charge, upon written request, all documents, records and other information that are relevant to the claim, to the extent permitted under applicable law.

Decisions on claims and appeals are made uniformly, in accordance with the terms and conditions of the governing Plan documents, and cannot be granted or paid unless authorized by those documents.

Benefits are not assignable, and any purported assignment of benefits to a provider or other person is void and confers no right to pursue a claim or appeal against the Plan. The Plan does not confer rights on any third-party beneficiary. A covered person is the only person legally entitled to receive payment of benefits from the Plan. However, the Plan in its discretion may pay benefits on behalf of a covered person directly to a provider of covered services or supplies, and any such payment will discharge the obligation of the Plan to pay the same benefits to the covered person. If the Plan elects to make payments directly to multiple providers, the Plan reserves the right to allocate the deductible amount among eligible charges and to apportion the benefits paid to each provider accordingly.

The Plan will not pay any “hospital surcharge” such as those imposed by the states of Massachusetts and New York.

The Plan will not under any circumstance, consider for payment a claim for medical, prescription drug, vision or dental benefits based on charges that were incurred more than 12 months prior to the date a claim is filed.

### Filing A Claim

#### Medical Benefits

A claim for medical benefits should be filed within 90 days after services are rendered.

Claims for medical benefits must be filed with the Plan. In most cases, if a claimant has paid any applicable copayment and furnished the provider with the Plan’s Medical ID card, a claim will be filed directly by the provider. It is the responsibility of an in-network provider to file accurate and timely claims with the Plan, and if an in-network provider fails to do so, the claimant will not be liable to the provider for the Plan benefits that would have been payable. If services or supplies are obtained from a non-network provider, it is the responsibility of the claimant to see that an accurate and timely claim is filed, by the provider or claimant. If a claimant pays a provider directly, the claimant may file a claim with the Plan for reimbursement of any Plan benefits that were due but not paid to the provider by the Plan. A claim for such reimbursement must be submitted on the Plan’s claim form, available at [www.carpdc.org/BenefitServices/Forms/](http://www.carpdc.org/BenefitServices/Forms/) or from the Plan Office. Claims must be submitted electronically at Emdeon Payer ID 25133 or to:

Carpenters’ Health and Welfare Trust Fund of St. Louis  
c/o Coventry Health Care  
P.O. Box 7796  
London, KY 40742
Prescription Drug Benefits

The Plan has contracted with Express Scripts to process claims for the Prescription Drug Benefit, to make Prior Authorization determinations, and for access to the drug Networks. Therefore, all claims for prescription drug benefits must be submitted directly to Express Scripts, regardless of whether from in-network or non-network providers.

Because prescription drug benefits are payable, except in an emergency, only for drugs purchased from an in-network provider, it is the in-network provider that is responsible for filing the claim. The filing and processing of in-network claims is automated at the point of sale, and the claimant will be informed then of the amount due from the claimant.

If a claimant obtains a covered drug from an in-network provider and pays the full charge because the claim for any reason is not processed at the point of sale, or if a claimant’s purchase of a drug from a non-network provider is covered as an emergency, the claimant may file a claim for reimbursement of Plan benefits. A claim for such reimbursement must be submitted to Express Scripts on an Express Scripts Drug Reimbursement claim form, which can be obtained at www.carpdc.org/BenefitServices/Forms/ or by calling the Benefit Office and requesting an Express Scripts’ claim form.

Vision Benefits

Claims for vision benefits must be filed with the Plan’s network sponsor, VSP. If a claimant obtains services or supplies from an in-network provider, and has paid any applicable copayment and furnished the provider with the Plan’s Vision ID card, a claim will be filed directly by the provider. It is the responsibility of an in-network provider to file accurate and timely claims with the Plan, and if an in-network provider fails to do so, the claimant will not be liable to the provider for the Plan benefits that would have been payable. If services or supplies are obtained from a non-network provider, it is the responsibility of the claimant to see that an accurate and timely claim is filed, by the provider or claimant. If a claimant pays a provider directly, the claimant may file a claim for reimbursement of any Plan benefits that were due but not paid to the provider by the Plan. A claim for such reimbursement must be submitted to VSP on a VSP claim form, which can be obtained at www.carpdc.org/BenefitServices/Forms/ or by calling the Benefit Office and requesting a VSP claim form.

Dental Benefits

The Plan has contracted with Delta Dental, LLP to process dental claims, and for access to dental provider networks. Therefore, all claims for dental benefits must be submitted directly to Delta Dental, regardless of whether from in-network or non-network providers. A claim for dental benefits should be filed within 90 days after services are rendered.

If a claimant obtains services or supplies from an in-network provider, and has paid any applicable copayment and furnished the provider with the Plan’s Dental ID card, a claim will be filed directly by the provider. It is the responsibility of an in-network provider to file accurate and timely claims with the Plan, and if an in-network provider fails to do so, the claimant will not be liable to the provider for the Plan benefits that would have been payable. If services or supplies are obtained from a non-network provider, it is the responsibility of the claimant to see that an accurate and timely claim is filed, by the provider or claimant. If a claimant pays a provider directly, the claimant may file a claim for reimbursement of any Plan benefits that were due but not paid to the provider by the Plan. A claim for such reimbursement must be submitted to:

Delta Dental of Missouri
PO Box 8690
St. Louis, MO 63126

Life Insurance and Accidental Death and Dismemberment Benefits

A claim under the Life Insurance and Accidental Death and Dismemberment (Life and AD&D) Benefit must be filed by the claimant on the Plan’s claim form at the Plan Office, 1419 Hampton Avenue, St. Louis, MO 63139. Notice of the loss should be given to the Plan within 20 days, and the claim form with supporting documentation should be filed within 90 days. Benefits will not be paid if the claim is filed more than 365 days after the date of the loss. If the claimant is eligible, the Plan will forward the claim to the company that insures this benefit for determination under the terms of the insurance policy.
Weekly Accident and Sickness Benefit and Other Disability Determinations

A claim under the Weekly Accident and Sickness Benefit must be completed by the claimant and attending physician on the Plan’s claim form, and filed by the claimant at the Plan Office, 1419 Hampton Avenue, St. Louis, MO 63139. The Plan may require additional examination of the claimant by a physician chosen by the Plan before making a determination on the claim. Claims for Weekly Accident and Sickness Benefits must be submitted to the Carpenters’ Benefit Office at 1419 Hampton Avenue, St. Louis, MO 63139 and received no later than 365 days from the initial date of disability.

If the Plan’s consideration of any benefit is based on a determination of a covered person’s Disability, the claim and appeals procedures for Weekly Accident and Sickness claims shall govern to the extent applicable.

Notification of Initial Benefit Determination

Urgent Care Claims

For purposes of these procedures, an “urgent care claim” is a claim for benefits for medical care or treatment with respect to which, as determined by the attending provider, the time periods applicable to non-urgent care claims could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A health care professional with knowledge of the claimant’s medical condition may act as the claimant’s authorized representative in connection with an urgent care claim.

The Plan will notify the claimant of the Plan’s benefit determination (whether adverse or not) of an urgent care claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to follow these procedures for filing the claim, or fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the proper procedures to be followed or the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking the circumstances into account, but not less than 48 hours, to provide the specified information. The Plan will notify the claimant of the Plan’s determination as soon as possible, but in no case later than 48 hours after the earlier of:

- the Plan’s receipt of the specified additional information, or
- the end of the period afforded the claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the Plan will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by a claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
Pre-Service Claims

For purposes of these procedures, a “pre-service claim” is a claim that is not an urgent care claim or concurrent care claim, for benefits for a service or supply for which the Plan requires Prior Authorization as a condition of receiving some or all benefits. If the claimant fails to follow these procedures for filing the claim, the Plan will notify the claimant as soon as possible, but not later than five days after receipt of the claim by the Plan, of the proper procedures to be followed or the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant.

The Plan (or its agent) will notify the claimant of the Plan’s determination (whether adverse or not) of a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to matters beyond the control of the Plan, additional time is needed to process a claim, the Plan may extend the time for notifying the claimant of the Plan’s benefit determination for up to 15 days, provided that within the first 15 days after receiving the claim, the Plan notifies the claimant of the circumstances requiring the extension of time and of the date by which the Plan expects to make its decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant will be afforded 45 days from receipt of the notice to provide the specified information.

Post-Service Claims

For purposes of these procedures, a “post-service claim” is a health care claim that is neither an urgent care claim nor a concurrent care claim nor a pre-service claim. The Plan will notify the claimant of the Plan’s adverse benefit determination of a compliant post-service claim within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to matters beyond the control of the Plan, additional time is needed to process a claim, the Plan may extend the time for notifying the claimant of the Plan’s benefit determination for up to 15 days, provided that within the first 30 days after receiving the claim, the Plan notifies the claimant of the circumstances requiring the extension of time and of the date by which the Plan expects to make its decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant will be afforded 45 days from receipt of the notice to provide the specified information.

Calculation of Time Periods

For purposes of these procedures, the period of time within which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision accompanies the claim. If a period of time is extended due to a claimant’s failure to submit all information necessary, the period for making the determination is tolled from the date the notification of extension is sent to the claimant until the earlier of the date the claimant responds to the request for additional information or the deadline for such response.
Manner and Content of Notification of Initial Adverse Benefit Determination

The Plan will provide notice of an initial adverse benefit determination to the claimant in writing or by electronic communication, except that such notice in the case of an urgent care claim may be provided orally followed within three days by written or electronic communication. Electronic communication shall comply with requirements of applicable law.

A notification of initial adverse benefit determination shall identify the claim by date of service, provider and claim amount. The notification shall include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provision on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim with an explanation of why such material is necessary;
- A statement that the claimant may receive on request the diagnosis code, the denial code, an explanation of the meaning of such codes;
- A description of available internal appeals and external review processes, with information regarding how to initiate an appeal; and
- A statement of the claimant’s right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, the notification shall so state and also state that a copy of the same will be provided free of charge upon request.

If the adverse determination is based on a medical necessity, experimental treatment, of similar exclusion or limit, the notification shall also include a statement that an explanation of the scientific judgment for the determination will be provided free of charge upon request.

If the adverse determination concerned an urgent care claim, the notification shall also include a description of the applicable expedited review process.

Appeal of Initial Adverse Benefit Determinations

If the Plan issues an initial adverse benefit determination, the claimant may appeal that denial to the Plan’s Board of Trustees under the following procedures. The Board of Trustees may delegate authority to decide such appeals to an appeals committee consisting of members of the Board of Trustees.

Filing a Request for Appeal of an Adverse Benefit Determination

A claimant has 180 days following receipt of a notification of an initial adverse benefit determination within which to request an appeal of the adverse determination. All requests for appeal of an initial adverse benefit determination (including all relevant information), other than denial of a pre-service claim, must be submitted to the Board of Trustees at the following address:

Carpenters’ Health and Welfare Trust Fund of St. Louis
Attn: Appeals Committee
1419 Hampton Avenue
St. Louis, MO 63139

All requests for appeal of a pre-service claim must be submitted to the appropriate network sponsor identified in the Plan.

In the case of an appeal of an initial adverse benefit determination of an urgent care claim, the claimant’s request for an expedited appeal may be submitted orally or in writing by the claimant and all necessary information, including the Plan’s determination on appeal, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

A claimant who requests an appeal shall be provided, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claimant’s claim for benefits.

A claimant who requests an appeal shall be entitled to submit written comments, documents, records, testimony and other information relating to the claim for benefits.
Manner of Deciding Appeals

An appeal will be considered and decided, without deference to the adverse initial benefit determination, by Members of the Board of Trustees who did not make the adverse initial benefit determination that is the subject of the appeal, and are not subordinates of the individual who made the adverse initial determination.

The Board of Trustees shall take into account all comments, documents, records, testimony and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

If the Board of Trustees considers, relies on, or generates any new or additional evidence (that was not submitted by the claimant), before making a final internal adverse benefit determination the Plan will provide such evidence to the claimant free of charge, as soon as possible and in time to give the claimant reasonable opportunity to respond before the deadline for issuing notice of a final internal adverse benefit determination.

Before making a final internal adverse benefit determination based on a new or additional rationale (other than that described in the notice of initial adverse benefit determination), the Plan will provide such rationale to the claimant free of charge, as soon as possible and in time to give the claimant reasonable opportunity to respond before the deadline for issuing notice of a final internal adverse benefit determination.

The Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on appeal of any adverse initial benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental or Investigative or medically necessary. The professional so engaged for consultation shall be an individual who was neither consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan provides one appeal of an initial adverse benefit determination. The decision of the Board of Trustees or their delegate is final and binding with respect to consideration by the Plan.

Notification of Decision on Appeal

Urgent Care Appeals: The Plan or its agent shall notify the claimant of the Plan’s decision on appeal of an urgent claim as soon as possible, taking into account the medical situation demanding prompt action, but not later than 72 hours after receipt of the claimant’s request for appeal of the initial adverse benefit determination by the Plan.

Pre-Service or Concurrent Care Appeals: The Plan or its agent shall notify the claimant of the Plan’s decision on appeal of a pre-service or concurrent care claim within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the claimant’s request for appeal of the adverse benefit determination.

Post-Service and Disability Appeals: The Plan shall make a decision on appeal of a post-service or disability claim no later than the date of the next meeting of the Board of Trustees or appeals Committee after the Plan receives a request for appeal, unless the request is filed within 30 days before that meeting, in which case the benefit determination will be made by no later than the date of the second meeting after the Plan receives the request. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting following the Plan’s receipt of the request for review, and the Plan will notify the claimant in writing if such an extension is needed, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan will notify the claimant of the benefit determination as soon as possible, but no later than five days after the benefit determination is made.

Calculation of Time Periods

For purposes of these procedures, the period of time within which a decision on appeal is required to be made begins at the time the appeal is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision on appeal accompanies the filing. If a period of time is extended due to a claimant’s failure to submit all information necessary, the period for making the decision on appeal is tolled from the date the notification of extension is sent to the claimant until the earlier of the date the claimant responds to the request for additional information or the deadline for such response.
Manner and Content of Notice of Decision on Appeal

The Plan will provide notice of an adverse benefit determination to the claimant in writing or by electronic communication. Electronic communication shall comply with requirements of applicable law.

A notification of final adverse benefit determination shall identify the claim by date of service, provider and claim amount, and shall include:

- The specific reason or reasons for the adverse determination, with discussion of the decision;
- Reference to the specific Plan provision on which the determination is based;
- A statement that the claimant is entitled to receive, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claimant’s claim for benefits;
- A statement that the claimant may receive on request the diagnosis code, the denial code, an explanation of the meaning of such codes;
- A description of available external review processes, with information regarding how to initiate an external review; and
- A statement of the claimant’s right to bring a civil action under section 502(a) of ERISA, with the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, the notification shall so state and also state that a copy of the same will be provided free of charge upon request.

If the adverse determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, the notification shall also include a statement that an explanation of the scientific judgment for the determination will be provided free of charge upon request.

If the Plan obtained advice from a medical or vocational expert in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination, the notification will identify such expert.

Miscellaneous Provisions Pertaining to Claims and Appeals

A claimant may designate another person to act as the claimant’s authorized representative for purposes of the Plan’s claims and appeals procedures. The designation should be made on a form which may be obtained from the Benefit Office. A person designated by any means other than the Plan’s approved form, or a document satisfying the requirements of a durable power of attorney for health care under the laws of Missouri, may not act as an authorized representative except as follows: A claimant’s spouse, or court-appointed guardian or conservator may act as the authorized representative of the claimant; a parent may act as the authorized representative of an eligible dependent child; and a licensed health care professional with knowledge of the medical condition of a claimant may act as the authorized representative of the claimant in case of an urgent care claim.

The Plan’s claims and appeal procedures are intended to comply with the Department of Labor’s claims procedure regulations as well as the claim requirements under the Patient Protection and Affordable Care Act (PPACA), and shall be interpreted accordingly. In the event of any conflict between this Plan Document and the applicable regulations, the regulations will control. In addition, any changes in the applicable regulations shall be deemed to amend this Plan Document automatically to conform to such changes, effective as of the date of those changes.

Under federal law a claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (“ERISA”) if dissatisfied with an adverse benefit determination. Before bringing such an action, the claimant must exhaust the Plan’s claims and appeals procedures. Any such action against the Plan under ERISA must be filed within two years of the date of the decision of the Trustees on appeal.
External Review Process

If a claim or internal appeal involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) a rescission of coverage, is denied by the Board of Trustees, the claimant will have the opportunity to request external review of the Board of Trustees decision according to the procedures described below.

Standard External Review

Standard external review is external review that is not considered expedited (as described below).

- A claimant may file a request for external review within four months after receipt of a notice that a claim or internal appeal was denied. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

- Within five business days after receipt of a request for external review, the Plan will complete a preliminary review to verify that the claimant was covered by the Plan at the time the service or supply in question was provided, that the claim or appeal denial was not based on ineligibility for coverage, that the claimant has exhausted the Plan’s internal claims and appeals processes (or is deemed under applicable regulations to have done so), that the claim or appeal denial is otherwise eligible for external review, and that the claimant has furnished all information required to process an external review.

- The Plan will notify the claimant in writing of whether the request is complete and the request is eligible for external review within one business day after completion of the preliminary review. If the request is not eligible for external review, the notice will explain why, and provide contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information needed, and the Plan will allow the claimant to perfect the request within the four-month filing period or, if longer, within 48 hours after receipt of the notice.

- The Plan will contract with at least three accredited Independent Review Organizations (IROs), and will assign eligible requests for external review to them in rotating order.

- Within five business days after assignment of a request to an IRO, the Plan will provide to the IRO the documents and information considered by the Plan in denying the claim or appeal.

- Regulations provide that the IRO will (1) notify the claimant of the request’s eligibility and acceptance for review and allow the claimant ten days to submit additional information for consideration; (2) forward any additional information submitted by the claimant to the Plan; (3) review the claim without consideration for the previous decisions made by the Plan; and (4) provide written notice to the Plan and the claimant of the IRO’s final decision within 45 days after receiving the request for external review. The decision notice will contain the receipt date of the review, a detailed description of the evidence or documentation considered, the principal reasons for the decision, a notification of the remedies available to either party under federal law, including judicial review available to the claimant, and contact information for health insurance consumer assistance ombudsman established under the Public Health Services Act.
Expedited External Review

If the claimant received a claim denial involving a medical condition of the claimant for which the time frame to complete an expedited internal appeal would seriously jeopardize the claimant’s life, health or ability to recover maximum function, and the claimant has filed a request for an expedited internal appeal; or if a claimant receives a denial of an internal appeal involving a medical condition of the claimant for which the time frame to complete a standard external review would seriously jeopardize the claimant’s life, health or ability to recover maximum function; or if the appeal denial concerns a health care condition for which the claimant received emergency services but has not been discharged from a facility, then in any such case, the claimant may request an expedited external review, which will be processed as follows:

- The Plan will conduct the preliminary review immediately upon receipt of the request for expedited external review.
- Upon determining that the request is eligible for external review, the Plan will assign the request to an IRO and transmit the required information and documents electronically or by telephone or facsimile or other available expeditious method.
- The Plan’s contract will require the IRO to provide notice of its decision to the Plan and the claimant as expeditiously as possible, but no later than 72 hours after receiving the request for expedited external review.
COBRA Continuation Coverage

Under COBRA, you and your covered dependents have the right to elect to continue your coverage under the Plan in lieu of minimum/difference payments if you (or your covered dependents) would otherwise lose coverage because of a qualifying event (as shown in the chart below). Each qualified beneficiary has the independent right to elect COBRA coverage. A qualified beneficiary means each person (you, your spouse and your dependents) covered by the Plan on the day before a qualifying event, and any child born to you or placed for adoption with you while you are covered by COBRA. You may elect (but you may not waive) COBRA continuation on behalf of your spouse, as long as your spouse is a qualified beneficiary. Parents may elect COBRA continuation coverage on behalf of their dependent children, as long as the dependent children are qualified beneficiaries.

Continuation coverage under COBRA includes medical, prescription drug, dental and vision coverage that the qualified beneficiary would have been entitled to if the qualifying event had not occurred. It does not include weekly accident and sickness benefits, life insurance, or AD&D.

An active member who maintains coverage after a qualifying event by electing COBRA in lieu of minimum/difference payments may not elect minimum/difference payments to maintain active coverage at the termination of the COBRA coverage, unless and until the member reestablishes initial eligibility as provided in the Plan. Conversely, an active member who maintains coverage after a qualifying event by electing minimum/difference payments in lieu of COBRA may not elect COBRA to maintain active coverage at the termination of the period of minimum/difference payments, unless and until the member reestablishes initial eligibility as provided in the Plan, or unless a second qualifying event occurs before such termination.
**Eligibility and Duration**

The following chart shows the qualifying events and the periods of eligibility for COBRA continuation coverage:

<table>
<thead>
<tr>
<th>If you lose coverage for any one of these reasons</th>
<th>These people would be eligible for COBRA continuation coverage</th>
<th>For up to this long</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment terminates for reasons other than gross misconduct</td>
<td>You and your eligible dependents</td>
<td>18 months*</td>
</tr>
<tr>
<td>You become ineligible due to reduced work hours</td>
<td>You and your eligible dependents</td>
<td>18 months*</td>
</tr>
<tr>
<td>You die</td>
<td>Your eligible dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You divorce or legally separate</td>
<td>Your eligible dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>Your dependent children no longer qualify as dependents</td>
<td>Your eligible dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>Your eligible dependents</td>
<td>36 months</td>
</tr>
</tbody>
</table>

*Subject to extension to up to 29 months, as described below.

Please note that entitlement to Medicare means you are eligible for and enrolled in Medicare. Also note that if you are entitled to Medicare at the time that your employment terminates or you become ineligible due to a reduction in hours and your Medicare entitlement began less than 18 months before the applicable qualifying event, your dependents will be eligible for up to 36 months of COBRA after the date of Medicare entitlement.

**Extension of 18-month COBRA coverage period for disability.** If you’re a qualified beneficiary who has COBRA continuation coverage because of termination of employment or reduction in hours, you and each enrolled member of your family can get an extra 11 months of COBRA coverage if you become disabled. (That is, you can get up to a total of 29 months of COBRA coverage.) To qualify for additional months of COBRA coverage, you must have a Notice of Award from the Social Security Administration that your disability began before the 61st day after your termination of employment or reduction in hours, and your disability must last at least until the end of the COBRA coverage period that would have been available without the extension.

To elect extended COBRA coverage, you must send a copy of the Social Security Administration’s determination to the Benefit Office, within 60 days of the date of the Social Security Administration’s determination notice (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest). In addition, your notification to the Benefit Office must occur within 18 months after your termination of employment or reduction in hours. If you do not notify the Benefit Office in writing within the 60-day (and 18-month) period, you will lose your right to elect extended COBRA continuation coverage.

**Extension of 18-month COBRA coverage period for your spouse or dependent children due to a second qualifying event.** If your spouse or dependent children have COBRA continuation coverage because of your termination of employment or reduction in hours, they can get up to an extra 18 months of COBRA coverage if they have a second qualifying event. (In other words, they can get up to a total of 36 months of COBRA coverage.) This extended COBRA coverage is available to your spouse and dependent children if the second qualifying event is your death, divorce, or legal separation. The extension is also available to a dependent child whose second qualifying event occurs when he or she stops being eligible under the Plan as a dependent child.

To elect extended COBRA coverage in all of these cases, you must notify the Benefit Office of the second qualifying event within 60 days after the second qualifying event (or the date that benefits would end under the Plan as a result of the first qualifying event, if later). If you do not notify ADP in writing within the 60-day period, you will lose your right to elect additional COBRA continuation coverage.
**Important Note**

If you have maintained your coverage eligibility through the use of minimum/difference payments for the maximum permissible coverage period, or if you have failed to make timely minimum/difference payments, your resulting loss of eligibility for coverage will *not* be considered a qualifying event entitling you to COBRA continuation coverage.

---

**Notification**

The Benefit Office will notify you or your dependents if you or your dependents become eligible for COBRA continuation coverage because of your death, termination of employment, reduction in hours of employment or Medicare entitlement. The notification must be made within 30 days after the qualifying event.

Under the law, you or your enrolled dependent is responsible for notifying the Benefit Office in writing of your divorce, legal separation or a child’s loss of dependent status. The notification must be made within 60 days after the qualifying event (or the date on which coverage would end because of the qualifying event, if later).

A disabled qualified beneficiary must notify the Benefit Office in writing of a disability determination by Social Security within 60 days after such determination (or the date of the qualifying event or the date coverage was or would be terminated as a result of the qualifying event, whichever is latest) and within the initial 18 months of COBRA coverage.

You or your dependent spouse can provide notice on behalf of yourself as well as other family members affected by the qualifying event. The written notice of the qualifying event should be sent to the Benefit Office, at the address shown on page 75, and should include the following:

- Date written notice is submitted (month/day/year)
- Employee’s name
- Employee’s Social Security number/ID number
- Reason for loss of coverage
- Loss of coverage date (month/day/year)
- Spouse/dependent’s name
- Spouse’s Social Security number/ID number
- Spouse/dependent’s address
- Spouse/dependent’s telephone number
- Spouse/dependent’s gender
- Spouse/dependent’s date of birth (month/day/year)
- Spouse/dependent’s relationship to employee

If you do not notify the Benefit Office in writing within the applicable period or you do not follow the procedures prescribed for notifying the Benefit Office, you will lose your right to elect COBRA continuation coverage.

**COBRA enrollment.** Within 30 days after the Benefit Office is notified that a qualifying event has occurred, they will send you an election form and a notice of your right to elect COBRA. To receive COBRA continuation coverage, you must elect it by returning a completed COBRA election form to the Benefit Office within 60 days after the date of the notice of your right to elect COBRA (or within 60 days after the date you would lose coverage, if later).

If you make this election and pay the required premium within the required deadlines, COBRA coverage will become effective on the day after coverage under the Plan would otherwise end.
Important Note

Within 30 days after the Benefit Office is notified that a qualifying event has occurred, they will send you an election form and a notice of your right to elect COBRA continuation coverage.

Instead of electing COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace or Medicaid. You may also be eligible for a “special enrollment period” in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying events. You will also have the same special enrollment right at the end of your COBRA coverage if you take COBRA coverage for the maximum time available to you. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Adding a Dependent

If a child is born to you (the employee) or placed for adoption with you while you are covered by COBRA, you can add the child to your coverage as a qualified beneficiary with independent COBRA rights. In addition, each qualified beneficiary covered by COBRA may add dependents in the same manner as an active employee, but such dependents are not qualified beneficiaries.

Cost of Coverage

As provided by law, you and/or your enrolled dependents must pay the full cost of coverage plus 2% for administrative expenses for the full 18- or 36-month period. For a disabled person who extends coverage for more than 18 months, the cost for months 19–29 is 150% of the Plan’s cost for the coverage. Since the cost to the Plan may change during the period of your continuation coverage, the amount charged to you may also change annually during this period.

Time for payment

You must send the initial payment for COBRA coverage to the Benefit Office within 45 days of the date you first notify the Benefit Office that you choose COBRA coverage. (A U.S. Post Office postmark will serve as proof of the date you sent your payment.) You must submit payment to cover the number of months from the date of regular coverage termination to the time of payment (or to the time you wish to have COBRA coverage end).

After your initial payment, all payments are due on the first of the month. You have a 30-day grace period from the due date to pay your premium. If you fail to pay by the end of the grace period, your coverage will end as of the last day of the last fully paid period. Once coverage ends, it cannot be reinstated. To avoid cancellation, you must send your payment on or before the last day of the grace period. (Again, a U.S. Post Office postmark will serve as proof.) Please note that if your check is returned unpaid from the bank for any reason, that may prevent your COBRA premiums from being paid on time and may result in cancellation of coverage.

When COBRA Continuation Coverage Ends

COBRA continuation coverage ends automatically on the last day of the month in which the earliest of the following dates falls:

- the date the maximum coverage period ends
- the last day of the period for which the person covered under COBRA made a required premium payment on time
- the date after the election of COBRA that the person covered under COBRA first becomes covered under another group medical plan.
- the first of the month that begins more than 30 days after the date the person whose disability caused the extension of coverage to 29 months is no longer disabled (based on a final determination from the Social Security Administration)
- the date the Plan is terminated and Carpenters provides no other medical coverage.

In addition, COBRA continuation coverage normally will end when the person covered under COBRA first becomes entitled to Medicare.

If continuation coverage ends before the end of the maximum coverage period, the Benefit Office will send you a written notice as soon as practicable following their determination that continuation...
coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

COBRA continuation coverage cannot under any circumstances extend beyond 36 months from the date of the qualifying event that originally made you or a dependent eligible to elect COBRA.

Once COBRA continuation coverage ends for any reason, it cannot be reinstated.

You must notify the Benefit Office if:

- you have a divorce or legal separation
- you, your spouse or an eligible enrolled dependent has a change of address
- you, your spouse or your dependent becomes entitled to Medicare
- your dependent child is no longer eligible
- you or a dependent ceases to be disabled, as determined by the Social Security Administration.

If you don’t notify the Benefit Office in a timely manner that any of the above events has occurred, you may lose COBRA coverage.

The COBRA Administrator for the Plan is:

Carpenters’ Health and Welfare Trust Fund
of St. Louis (The Benefit Office)
1419 Hampton Avenue
St. Louis, MO 63139
877-232-3863

All notices to the Benefit Office must be in writing and sent to this address. Any notice that you send by mail must be postmarked by the U.S. Post Office no later than the last day of the required notice period. The notice must state the name of the Plan under which you request COBRA continuation coverage, your name and address, the name and address of each qualifying beneficiary, the qualifying event and the date it happened. If the qualifying event is a divorce or legal separation, you must include a copy of the divorce decree or legal documentation of the legal separation. Other applicable documentation (such as birth certificates or adoption papers) may also be required.

Unavailability of coverage. If you or your enrolled dependent has notified the Benefit Office in writing of your divorce, legal separation or a child’s loss of dependent status, or a second qualifying event, but you or your enrolled dependent is not entitled to COBRA, the Benefit Office will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same time frame the Plan follows for election notices.

If You Have Questions

If you have any questions about your COBRA continuation coverage, contact the Benefit Office or the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Addresses and phone numbers of EBSA offices are available at www.dol.gov/ebsa.

To protect your family’s rights to COBRA coverage, keep the Benefit Office informed of any changes of address for you and your family members.
Coordination of Benefits with Other Medical Plans

The medical, prescription drug, dental and vision benefits of the Plan are subject to a “coordination of benefits” (COB) provision. This means that if you or your dependents are covered under this Plan and are also covered by another health plan, this Plan will coordinate benefits with another plan so that the total benefits from all plans do not exceed 100% of the allowable amount.

Under coordination of benefits, one plan is considered “primary” and the other “secondary.” When this Plan is primary, it determines payment for its benefits first, before those of any other plan, without considering any other plan’s benefits. When this Plan is secondary, it determines its benefits after those of another plan, and may reduce the benefits it pays so that all benefits from all plans do not exceed 100% of the total allowable amount or more than the patient liability after the primary plan pays.

The Plan will coordinate benefits with other plans that provide medical, prescription drug, vision or dental care, including:

- Any group or non-group insurance, health maintenance organization (HMO) or other forms of group or group-type coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal or state governmental plan, including plans purchased through the Health Insurance Marketplace as permitted by law. (This does not include Medicaid.)
- Any self-insured or non-insured plan arranged through an employer, trustee, union, employer organization, or employee benefit organization.
- Any hospital service pre-payment plan, medical service pre-payment plan, group practice and any other pre-payment coverage.
- Any coverage for students provided through a school or educational institution.
- The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts.

The Plan does not coordinate benefits with hospital indemnity-type contracts.
Coordination of Benefits: An Example

Here’s an example of how the Plan coordinates benefits with another plan. Start with some basic assumptions:

- A member has a $250 charge.
- The member has other coverage which is primary in this instance, and this Plan is secondary.
- The other plan and this Plan have different allowable amounts for the charge and different coinsurance terms.
- The deductible that the member must meet is different under the two plans.

<table>
<thead>
<tr>
<th></th>
<th>The Other Plan (Primary)</th>
<th>This Plan (Secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed amount</td>
<td>$250.00</td>
<td>$250.00</td>
</tr>
<tr>
<td>Provider discount</td>
<td>$50.00</td>
<td>$25.00</td>
</tr>
<tr>
<td>Allowable amount</td>
<td>$200.00</td>
<td>$225.00</td>
</tr>
<tr>
<td>Deductible applied</td>
<td>$50.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>Allowed after deductible</td>
<td>$150.00 @ 80% = $120.00</td>
<td>$125.00 @ 90% = $112.50</td>
</tr>
<tr>
<td>Maximum amount available to pay</td>
<td>$120.00</td>
<td>$112.50</td>
</tr>
<tr>
<td>Amount paid</td>
<td>$120.00</td>
<td>$80.00</td>
</tr>
<tr>
<td>Patient responsibility</td>
<td>$80.00</td>
<td>$0</td>
</tr>
</tbody>
</table>

In this example, the allowable amount under the primary plan is $200. That plan pays 80% after the member’s deductible has been satisfied, or $120. The member’s responsibility is thus $80.

This Plan, as the secondary plan, will pay up to the patient responsibility after the primary plan pays, but not more than what this Plan would pay if were paying as the primary plan.

If this Plan had been primary, it would have paid the charge as illustrated in the shaded rows in the chart: the allowable charge would have been $225, and the allowed amount after the member’s deductible is applied would be $125. The Plan would have paid 90%, or $112.50. But because the member’s responsibility under the primary plan is just $80, that is the amount the Plan will pay.

Determining Which Plan Is Primary

When a person is covered by two or more plans, the rules for determining which plan is primary — i.e., the plan that pays first — are as follows:

- This Plan is generally primary for you when you are an active member.
- When a plan does not contain a coordination of benefits provision (such as an HMO), that plan is generally primary.
- Plans designed to supplement another plan (and pay charges excluded by that plan) are always secondary.
- A plan that provides benefits on an excess insurance or excess coverage basis will always be primary to this Plan.
If the previous terms do not apply or do not establish which plan is primary, the determination of which plan is primary can be made according to the following provisions:

**Non-dependent or dependent.** The plan that covers the person other than as a dependent — for example, as an employee, member, policyholder, subscriber or retiree — is the primary plan and the plan that covers the same person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary, and if, under federal law, Medicare is secondary to the plan covering the person as a dependent, then the order of benefits between the two plans is reversed, so that the plan covering the person as a dependent is primary and Medicare is secondary.

**Dependent child covered under more than one plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

- For a dependent child whose parents are married or living together, the “birthday rule” applies; the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a dependent child whose parents are divorced, separated or living apart, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the dependent child’s health care expenses, that plan is primary;
  - If a court decree states that both parents are responsible for the dependent child’s health care expenses, the birthday rule applies;
  - If a court decree states that the parents have joint custody without specifying responsibility for the dependent child’s health care expenses, the birthday rule applies;
  - If there is no court decree allocating responsibility for the dependent child’s health care expenses, the order of benefits for the child is as follows:
    - The plan covering the custodial parent;
    - The plan covering the spouse of the custodial parent;
    - The plan covering the non-custodial parent;
    - The plan covering the spouse of the non-custodial parent.
- If a dependent child is covered under more than one plan of individuals who are not the parents of the child, the provisions above shall determine the order of benefits as if those individuals were the parents of the child.
- For a dependent child who has coverage under either or both parents’ plans and also has coverage as a dependent under his or her own spouse’s plan, the rule of longer or shorter coverage applies (the plan that has covered the parent the longest applies). If the dependent child’s coverage under the spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined by applying the birthday rule to the dependent child’s parent(s) and the dependent’s spouse.
- For a dependent stepchild, this Plan will always be the secondary plan.

**Active employee or retired or laid-off employee.** The plan that covers a person as a currently working active employee is the primary plan for the employee and dependents. The plan covering that same person as a retired or laid-off employee is the secondary plan for the employee and dependents. (This rule is inapplicable if the other plan does not have a comparable rule, or if the rule stated above under **Non-dependent or dependent** can determine the order of benefits.)

**COBRA or other continuation coverage.** A plan that covers a person under COBRA or other continuation coverage required by law is secondary to a plan that covers the person without continuation coverage as an employee, member subscriber or retiree or as a dependent of an employee, member, subscriber or retiree. (This rule is inapplicable if the other plan does not have a comparable rule, or if the rule stated above under **Non-dependent or dependent** can determine the order of benefits.)

**Longer or shorter length of coverage.** The plan that has covered the person as employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.
Impact on Benefits

When this Plan is primary, the benefits paid under the secondary plan will be disregarded in determining the benefits the Plan pays.

A plan determined to be secondary will calculate the benefits it would have paid in the absence of other health care coverage, and then apply that calculated amount to any allowable expense under its plan that has not been paid by the primary plan. The secondary plan may then reduce its payment so that, when combined with the amount paid by the primary plan, the total benefits paid or provided for the claim by both plans do not exceed the total allowable expense for that claim or the patient liability. The secondary plan shall also credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

When this Plan is secondary in coordinating benefits with a primary plan, the claim for benefits from this Plan must be filed no later than one year from the date the covered charges are incurred. The claim must include a copy of the explanation of benefits issued by the primary plan, as well as a copy of the provider’s itemized bill. The filing deadline is not extended on account of delay in processing by the primary plan, or on account of later related claims. Network sponsors may have specific filing requirements based on their network contracts; these filing requirements may impose shorter deadlines than the Plan’s filing requirement. Refer to Filing a Claim on page 62, in the Claims and Appeals section.

If two spouses are both covered under this Plan as members, the Plan will coordinate benefits. However, the Plan will not pay more than 100% of the allowable expense or more than the patient liability after the primary plan pays.

Coordination with Medicare

This Plan will be primary to Medicare for members in the active classification, and their dependents, who qualify for Medicare due to age. The exceptions to this rule are as follows: The Plan will be secondary to Medicare for a member in the active classification (and the dependent of such member) who works for a “small employer” within the meaning of the Medicare regulations. The Plan will also be secondary to Medicare for a member in the active classification (and a dependent of such member), who is first entitled to Medicare because of end-stage renal disease, after 30 months of Medicare coverage.

Right to Receive and Release Needed Information

The Trustees are authorized to exchange with other plans, insurance companies or other persons such information as is necessary for the purpose of coordinating benefits between this Plan and any other plan. Any person claiming benefits under this Plan agrees, as a condition of receiving such benefits, to furnish to the Trustees any information necessary to implement the provisions of the Plan’s coordination of benefits rules.

Payment Adjustments

If benefit payments that should have been made by this Plan in accordance with its coordination of benefits rules have instead been made by any other plan, the Trustees have the right to pay over to the other plan any amounts the Trustees determine to be warranted according to the terms of the Plan’s coordination of benefits rules. Any amounts so paid will be deemed to be benefits paid under this Plan.

Right of Recovery

If benefit payments have been made by this Plan with respect to allowable expenses in excess of the total amount of payment necessary to comply with the Plan’s coordination of benefits rules, the Trustees have the right to recover such excess from one or more of the persons it has paid, or from the covered person for whom such benefits were paid; or any other person or organization that may be responsible for the benefits or services provided to the covered person. Such payment shall be returned in a lump sum or deducted from future covered claims. The amount of benefit payments made includes the reasonable cash value of any benefits provided in the form of services.
If a covered person sustains an injury or sickness for which a third party may be or is liable to make payment or does make payment, the Plan is not obligated to pay any benefits on account of such injury or sickness, except as provided in this section.

If the Trustees determine, in their discretion, that there is a reasonable likelihood that a third party is liable to make payment to a covered person for an injury or illness, the Trustees may withhold benefits from the covered person for the injury or illness until the liability of the third party is finally determined. In their discretion, the Trustees may instead advance benefits to the covered person who sustained the injury or sickness, subject to the subrogation and reimbursement provisions of the Plan.

The Plan shall advance benefits for covered expenses related to such illness or injury only to the extent not paid by the third party and only after the covered person and his or her attorney (as applicable) have entered into the Plan’s written subrogation and reimbursement agreement in its entirety. If the covered person and/or the attorney (as applicable) fails to sign and deliver an agreement requested by the Plan, the Trustees may decline to advance any benefits before the liability of the third party has been determined.

A covered person’s own automobile insurance carrier is deemed a third party with respect to uninsured or underinsured coverage.

Any payment made by a third party on account of an injury or sickness covered by the Plan is referred to herein as a “third-party recovery.”

A covered person is not required to accept an advance of benefits in case of an injury or sickness for which a third party may be liable to make payment or does make payment. By accepting an advance of benefits related to such injury or sickness, the covered person and his or her attorney, (as applicable) accept and agree to fully comply with these subrogation and reimbursement provisions of the Plan.

**Subrogation**

- In any instance in which benefits are advanced or otherwise paid by the Plan on account of a covered person’s injury or sickness, the Plan is subrogated, to the extent of benefits paid, to all rights and claims of the covered person against any third party who may be liable for such injury or sickness.

- The Plan, after giving notice to the covered person and his or her attorney (as applicable), may (but is not obligated to) institute and prosecute any legal action in the name and on behalf of the covered person against any potentially liable third party, and if a recovery is had, the Plan shall be entitled to receive and retain therefrom the amount of benefits paid and all costs, expenses and attorney’s fees incurred in obtaining such recovery, and shall pay over any excess to the covered person. The Trustees shall have the right in their discretion to compromise and settle the amount of any such claim pursued directly by the Plan on behalf of a covered person.

- The Plan, as subrogee of a covered person, shall have the right to receive directly any payment due the covered person on account of an injury or sickness for which the Plan has paid benefits, whether or not the Plan acted on behalf of the covered person in procuring such payment.
Reimbursement Obligation

In the event that a covered person shall recover any amount from a third party, by judgment, settlement or otherwise, for an act or omission causing (in whole or in part) an injury or sickness for which the Plan paid benefits, the covered person shall be obligated to immediately reimburse the Plan for all such benefits paid, on the following terms and conditions:

- The amount of the covered person’s reimbursement obligation is the full amount (100%) of benefits paid by the Plan for such injury or sickness, undiminished by attorney’s fees or otherwise; provided, however, that the reimbursement obligation shall not exceed the full amount (100%) of the third-party recovery, undiminished by attorney’s fees or otherwise. The amount of the third-party recovery is the gross amount paid by a third party on account of the act or omission, irrespective of whether any part of the recovery is allocated, by judgment or agreement, to components of damage other than medical expense.

- The Plan specifically rejects the “common Fund” doctrine and is not obligated to pay or contribute to or be charged for any part of any attorney’s fees or other expenses incurred by a covered person to obtain a third-party recovery. All such fees and expenses are the obligation of the covered person alone. In the event that the gross amount of a third-party recovery is insufficient to pay in full the reimbursement owed to the Plan plus such fees and expenses, the Trustees may in their discretion (but are not obligated to) compromise any part of the reimbursement obligation of the covered person, as the Trustees deem just and in the best interests of the Plan.

- The covered person’s reimbursement obligation shall be secured by a first lien in favor of the Plan on the gross third-party recovery, prior to all other claims or liens including those for attorney’s fees. The covered person shall have no right or power to defeat or diminish the Plan’s lien by committing all or part of a third-party recovery to another person or entity. The Plan may notify the third party, his or her insurer, his or her attorney, or anyone else of the Plan’s lien and other rights with respect to a third-party recovery. The third-party recovery, to the extent of the Plan’s interest therein, is a plan asset and the covered person and his or her attorney and anyone else in possession of the third-party recovery shall hold the same in trust, as trustee, for the benefit of the Plan, to be applied first in satisfaction of the of the covered person’s reimbursement obligation to the Plan.

- The covered person’s reimbursement obligation is a debt owed by the covered person to the Plan, independent of the third-party recovery fund. If for any reason the reimbursement obligation is not promptly paid in full from the third-party recovery fund, the unpaid balance remains due and owing. In order to recover any unpaid reimbursement obligation of a covered person, the Trustees in their discretion may withhold, and apply to such obligation, benefits (whether or not related to the same claim) that otherwise become payable to the covered person or to any other member of the group to which the covered person belongs that consists of a member of this Plan and the member’s dependents.

- A member is responsible for performing all obligations of a covered person who is the member’s eligible spouse or other eligible dependent.

- The Plan specifically rejects the “make whole” doctrine. The Plan’s rights to reimbursement and subrogation do not depend on whether the covered person recovers from third parties monies sufficient to fully compensate the covered person for all of his or her losses.

- If a covered person receives a third-party recovery in excess of benefits paid out at that time, and reimburses the Plan for all such benefits paid, and if additional benefits are claimed thereafter on account of the same injury or sickness, the Plan is not obligated to pay such additional benefits until the sum of all benefits paid and claimed for that injury or sickness exceeds the gross amount of the third-party recovery.

- If a covered person receives a third-party recovery that is less than benefits paid to that time, the plan may require an uninsured or underinsured motorist claim to be filed against the covered person’s automobile insurance policy in order to satisfy the balance of the covered person’s reimbursement obligation.
Duty to Cooperate with the Plan

- Upon retaining an attorney in connection with a third-party claim, the covered person must promptly notify the Plan of the name, address and telephone number of the attorney, and must inform the attorney that the Plan’s rights of subrogation and reimbursement are not subject to any decrease for attorney’s fees.

- If the Trustees decide to advance benefits for an injury or sickness for which a third party may be or is liable, the Plan may require at any time, as a condition of commencing or continuing to pay benefits, that the covered person and/or the member (if the member is not the covered person) sign a written agreement may which contain a confirmation of the reimbursement obligations of the covered person, an assignment to the Plan of any third-party recovery received, a confirmation of the lien of the Plan on such recovery, or other terms satisfactory to the Plan. If the covered person is represented by an attorney, the Plan may require the attorney to sign the subrogation and reimbursement agreement to signify that the attorney accepts and will comply with the Plan’s subrogation and reimbursement provisions. However, the Plan’s rights are not dependent upon any such agreement.

- A covered person is obligated to take all actions reasonable in the circumstances to prosecute a claim against a third party who may be or is liable for an injury or sickness covered by the Plan.

- A covered person must inform the Plan promptly, in writing, of any claim which he or she asserts against a third party on account of an injury or sickness for which benefits are paid or payable, and furnish to the Plan the name and address of the third party, the name of the third party’s insurance company and attorney, if any, the basis of the claim, and any other relevant information requested by the Plan. In addition, in the case of injuries caused by a third party as a result of an automobile accident, a covered person must also furnish to the Plan the name, address and policy number of the covered person’s automobile insurance company.

- A covered person shall cooperate with the Plan and do whatever is necessary to secure the rights of the Plan. The covered person shall do nothing to prejudice the Plan’s rights of subrogation and reimbursement. In the event that a covered person refuses to accept a settlement offer for a third-party claim unless the Plan waives any of its rights under this section, the Plan is released from its obligation to pay benefits to the extent of the refused offer.

- In the event that the Plan has declined to advance benefits under the provisions of this section for an injury or sickness for which a third party may be or is liable, and the covered person and his or her attorney have complied with their obligations under this section, and it is established to the satisfaction of the Trustees, in the exercise of their discretion, that no third-party recovery can be had, or that a third-party recovery cannot be had in an amount at least equal to the benefits withheld, then in such event the Plan shall pay the withheld benefits reduced by the amount of any third-party recovery achieved.

Right of Offset and Recovery

The Trustees reserve the right to stop the advance of benefits and to recover any benefits previously advanced in the event that:

- The covered person or his or her attorney if any, fails to fully comply with the subrogation and reimbursement provisions; or

- The Trustees, in the exercise of their discretion, determine that there is a likelihood that the covered person or his or her attorney if any, will fail to fully comply with the subrogation and reimbursement provisions of this Plan.

In either such event, the Trustees have the right to offset and recoup the benefits previously advanced by withholding benefits (whether or not related to the same claim) that otherwise become payable to the covered person or to any other member of the group to which the covered person belongs that consists of a member and his or her eligible dependents. The Trustees may also bring a legal action against the member and the covered person on whose behalf the benefits were advanced. If the Trustees find it necessary to file suit to recover the benefits advanced, and they prevail in such proceeding, both the member and the covered person on whose behalf the benefits were advanced will be responsible for paying the Trustees’ reasonable attorney’s fees and costs.
**Important Legal Information**

**Notice of Privacy Practices – HIPAA Information**

**THIS SECTION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**Introduction**

This notice is given by the Carpenters’ Health and Welfare Trust Fund of St. Louis, referred to herein as the “Plan.”

Under federal law, group health care plans are required to notify participants and beneficiaries about how the Plan will use and disclose “individually identifiable health information” (described below). The federal requirements are set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations issued under HIPAA.

“Individually identifiable health information” is also referred to in the law as “protected health information” (PHI). PHI is information about an individual’s health, health care or health benefits that enables the individual to be identified.

The use of the word “you” in this Notice refers to individual participants and covered dependents in the Plan. Occasionally a reference is made to a specific section in the applicable HIPAA regulations; the full text of these sections may be obtained from the Benefit Office.

HIPAA requires your Health and Welfare Plan to maintain the privacy of PHI in accordance with federal regulations. HIPAA also requires the Plan to notify participants and beneficiaries about their privacy rights, and the Plan’s privacy practices, with respect to PHI. The effective date of this Notice is January 1, 2015.

**Use or Disclosure of PHI without Your Permission**

When necessary to comply with section 164.514(e) of the HIPAA regulations, the Plan will use, disclose or request your PHI in the form of a “limited data set,” which does not contain direct identifiers such as names, addresses and Social Security numbers.

Under the HIPAA regulations, the Plan is permitted to use and disclose your PHI without your consent or authorization for the following purposes: (1) your treatment; (2) processing and payment of your claims; and (3) health care operations. Examples of use and disclosure of PHI for these purposes follow.

**Treatment:** A doctor or hospital may need to check with the Plan to make sure you are eligible for coverage or, may need to know from the Plan who has treated you previously, what the earlier diagnosis was, and what treatment was prescribed.

**Claims Processing and Payment:** The Plan usually receives a bill from each service provider (e.g., hospital, physician, lab, clinic, etc.) containing PHI such as a diagnosis code and a treatment code for a specific patient. The Plan uses this information to process the claim on the computer and to generate a check for the appropriate payment of the service provider in accordance with the Plan’s rules.

**Health Care Operations:** The Plan uses PHI for care management of specific patients (such as trauma, diabetics, heart patients, cancer patients, transplants, etc.), for providing insurance carriers with data needed to quote premiums to the Plan, for reviewing the competence or qualifications of various health care providers, for utilization review where alternative treatment options are available, and for detection of fraud or abuse.

The Plan may disclose your PHI to the Fund’s Board of Trustees if necessary to permit the Board to perform its functions with respect to the Plan.

In appropriate cases, the Plan may use your PHI to contact you to provide information about treatment alternatives.

When the Plan uses or discloses PHI, the Plan will make reasonable efforts to limit the PHI - to the “minimum necessary” to accomplish the intended purpose, in accordance with section 164.502(b) of the HIPAA regulations.
Other Purposes for Which Your PHI May Be Used or Disclosed Without Your Permission

In addition to the purposes described above, there are a number of other purposes for which the HIPAA regulations permit or require the Plan to use or disclose your PHI without obtaining consent or authorization from you, including:

1. Responding to public health agencies such as those authorized to collect or receive health information for the purposes of preventing or controlling disease, injuries, or disabilities.

2. Responding to public health agencies or social service agencies or protective services agencies authorized by law to receive reports of child abuse, neglect, or domestic violence.

3. Responding to a court order, subpoena or other legal process in a judicial or administrative proceeding.

4. Responding to a request from a health oversight agency authorized by law to conduct: audits; civil, administrative, or criminal investigations; inspections; licensure or actions against health care providers; or other activities designed to protect the health care system.

5. Responding to inquiries from law enforcement agencies that require reporting of certain kinds of wounds or physical injuries or to assist with the identification or location of a suspect, fugitive, material witness, victim or missing person.

6. Responding about deceased persons from medical examiners, funeral directors or organ procurement organizations to assist in carrying out their respective duties.

7. Responding to requests from health research agencies provided that approvals and waivers prescribed in the HIPAA regulation have been obtained.

8. When believed necessary to avert a serious and imminent threat to health or safety of a person or the public, or to assist in apprehension of a criminal suspect.

9. To assist in the performance of specialized government functions authorized by law, including activities of the armed forces, national security and intelligence agencies, the Secret Service, the State Department and correctional institutions.

10. To the extent necessary to comply with workers’ compensation laws.

In addition to the foregoing, the HIPAA regulations permit or require the Plan to use or disclose PHI without obtaining your consent or authorization in order to respond to an investigation of the Plan by the U.S. Department of Health and Human Services; or in circumstances in which you have been informed of the use or disclosure in advance and did not object; or to transmit the PHI to an entity that provides services to the Plan and has agreed by contract to protect the privacy of PHI received from the Plan.

Use or Disclosure of PHI Requiring Your Permission

Uses and disclosures of your PHI other than those described above will be made only with your written authorization. As examples, your authorization is required, with very limited exceptions, for use or disclosure of psychotherapy notes, or of other PHI for purposes of marketing or sale. You may revoke any such authorization at any time, as provided by section 164.508(b)(5) of the HIPAA regulations.

If you wish to authorize the use or disclosure of any PHI requiring your permission, contact the Benefit Office for an Authorization Form. The Form will ask you what PHI may be used or disclosed, who may receive designated PHI, when the Authorization expires, and indicate your right to revoke the Authorization.

Your Rights Regarding Your Own PHI

1. You may request that restrictions be placed on the Plan’s uses and disclosures of your PHI for treatment, payment of claims or health care operations in accordance with Section 164.522(a) of the HIPAA regulations. Your request must be submitted to the Benefit Office in writing.

   However, the Plan is NOT required to agree to a requested restriction except in the case of a disclosure protected under section 164.522(a)(1)(vi) of the HIPAA regulations. If the Plan agrees to your restriction, the Plan may still be required to release such information for emergency treatment, law enforcement, or other purposes specified by law.

2. You may request that the Plan take special measures to protect the confidentiality of PHI sent to you by the Plan by using alternative means, or alternative locations, specified by you, for any communication to you that contains your PHI. The Plan will accommodate such a request if it is reasonable, is made to the Plan in writing, and includes your statement that disclosure of all or part of the PHI covered by the request
could endanger you. The Plan may condition compliance with such a request on information as to how you will handle the payment of any additional costs incurred by compliance.

3. You may ask to inspect or to copy your PHI found in a “designated record set” under the conditions set forth in Section 164.524 of the HIPAA regulations. A “designated record set” is: (1) enrollment, payment, claims adjudication, and care management records maintained by the Plan on individual participants and beneficiaries; and (2) any other records of the Plan used to make decisions about participants and beneficiaries. Generally the Plan will not have detailed medical records but will have only computer coded data needed to process a claim submitted by a health care provider.

   a. If you wish to examine or copy a designated record set, the request must be in writing. If the request is granted the Plan will arrange a convenient time and place for you to inspect and/or copy the PHI requested. The Plan will discuss with you in advance the scope, format, and other aspects of the request in order to facilitate the timely provision of the requested PHI. Access will be provided when possible within 30 days after the request is first received by the Benefit Office.

   b. If the Plan denies you access to your PHI, you will receive a written denial explaining the reason(s) for the denial and the procedures to be followed if you wish the denial to be reviewed.

   c. If you want copies of the PHI, there will be a charge based on the cost of reproduction and for postage if you want the copies mailed. The Plan will tell you what these charges are before copying begins.

4. You have the right to request to request the Plan to amend your own PHI contained in a designated record set, if you believe it is inaccurate or incomplete, in accordance with the procedures set forth in Section 164.526 of the HIPAA regulations.

   The request must be submitted in writing, stating the reason for the request. When possible, the Plan will respond to your request for correction of your PHI within 60 days after receipt of your request. If approved, the Plan will notify you and other parties you identify (such as health care providers or clearinghouses) about the corrections in your PHI.

   If the change is disapproved by the Plan, you will be notified in writing about the reason(s) for denial of your request, about your right to disagree with the denial, and about the appeal procedures.

5. You have the right to request an accounting of disclosures of your PHI made by the Plan in accordance with the procedures set forth in section 164.528 of the HIPAA regulations.

   The accounting will include:

   a. The date of the disclosure;
   b. The name and address of the entity or person to whom your PHI was disclosed;
   c. A brief description of the PHI disclosed; and
   d. The reason for the disclosure.

   When possible, the Plan will provide this information within 60 days after your request is received by the Benefit Office. The Plan may impose a charge for more than one accounting requested in a twelve month period.

6. You have the right to receive a paper copy of this Notice from the Plan on request.

7. If you request an accounting of disclosures of your PHI, the accounting must include disclosures made within the past 3 years to carry out treatment, payment and healthcare operations if the Plan made such disclosures through an electronic health record.

8. If the Plan maintains an electronic health record containing PHI that you are entitled to receive, the Plan must comply with your request for a copy of such PHI in electronic format, and may charge no more that the Plan’s labor cost to comply with the request.

9. If you request the Plan not to disclose your PHI to another health Plan for purposes of carrying out payment or health care operations, and if the PHI relates solely to health care for which the provider has been paid out of pocket in full, then the Plan must comply with your request.

10. If the Plan should use your PHI for underwriting purposes, the Plan is prohibited from using PHI that is genetic information for such purposes.
Breach of PHI

If the Plan discovers that a “breach” of your unsecured, protected health information (PHI) has occurred, the Plan is required to notify you about the breach.

Plan’s Right to Change Privacy Practices

The Plan reserves the right to change the terms of this Notice at any time and to make the provisions of the new Notice effective for all PHI that the Plan maintains.

Any revised Notice will be distributed to individuals via U.S. mail (and email, if applicable) at least 30 days before the effective date of the new notice. Any revised Notice will also appear in the Cutting Edge, the Benefits Builder and the Website located at www.carpdc.org/BenefitServices.

A copy of the latest notice may be obtained at any time by contacting the Benefit Office by letter, phone, fax, or email.

The Plan is required by law to abide by the terms of the Notice currently in effect.

Medicare Part D Disclosure – Medicare Modernization Act (MMA)

The Plan will disclose to or on behalf of the Fund, such PHI as the Centers for Medicare and Medicaid Services may require to enable the Fund to receive payment for participating in the Medicare Part D program pursuant to 42 CFR Part 423. PHI disclosed under this provision may be used solely for the purpose of obtaining the Medicare Part D subsidies and for no other purpose.

Need Help?

If you have any questions concerning this privacy notice or your privacy rights contact the Benefit Office by phone at 314-644-4802 or toll-free 877-232-3863, by fax 314-644-0200, or email benefits@carpdc.org, or by letter addressed to:

Carpenters’ Health and Welfare Fund
ATTENTION: Privacy Officer
1419 Hampton Avenue
St. Louis, Missouri 63139

PLEASE ADDRESS YOUR REQUEST TO THE FUND’S “PRIVACY OFFICER.”

If you are not satisfied with the answer(s) received from the Benefit Office, you may wish to contact the U.S. Department of Health and Human Services (HHS). Ask the Fund’s Privacy Officer for the name and address of the appropriate HHS contact person.

Individuals who believe their privacy rights have been violated may complain to the Plan and to the Secretary of Health and Human Services. A complaint to the Plan may be filed with Plan’s Privacy Officer. An individual may not be retaliated against for filing a complaint.

A Final Reminder

The Benefit Office staff will make every reasonable effort to protect the confidentiality of your medical data in accordance with federal laws and regulations. If you have questions or complaints, please contact the Privacy Officer at the Benefit Office first.
Women’s Health and Cancer Rights Act of 1998

The Women’s Health and Cancer Rights Act of 1998 requires that all group medical plans that provide medical and surgical benefits with respect to a mastectomy must provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, coinsurance and copay provisions applicable to other such medical and surgical benefits provided under the Plan.

The Newborns’ and Mothers’ Health Protection Act of 1996

Under federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Continued Coverage Under the Federal Family and Medical Leave Act

If you take a leave that qualifies under the federal Family and Medical Leave Act (FMLA), you may maintain your coverage under the Plan. You will be subject to the same rules regarding deductibles, coinsurance, etc., as an active member. Contact the Benefit Office for more information.

Continued Coverage During a Military Leave of Absence

If you are on a military leave of absence, your and your dependents’ coverage under the Plan will continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Contact the Benefit Office for more information.
## Administrative Plan Information

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>The Plan is the Carpenters’ Health and Welfare Trust Fund of St. Louis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Sponsor and Plan Administrator</td>
<td>The administrator is the Board of Trustees of Carpenters’ Health and Welfare Trust Fund of St. Louis, 1401 Hampton Avenue, St. Louis, MO 63139, 314-644-4800. The Trustees are responsible for the operation of the Plan. Any administrative services provider will provide duties specified in a separate Administrative Services Agreement entered into between that provider and the Trustees. A complete list of employers and employee organizations sponsoring the Plan may be obtained upon written request to the administrator, and is available for examination at the administrator’s office. Upon written request to the administrator, participants and beneficiaries may receive information as to whether a particular employer or employee organization is a sponsor of the Plan and if so, the sponsor’s address.</td>
</tr>
<tr>
<td>Contributions and Funding Medium</td>
<td>Contractually determined contributions are made to the Plan by employers and self-payments are made by members in amounts determined by the Trustees. Contributions are made to the Carpenters’ Health and Welfare Trust Fund of St. Louis, which provides funding for benefits.</td>
</tr>
<tr>
<td>Employer Identification Number</td>
<td>43-0685432</td>
</tr>
<tr>
<td>Plan Number</td>
<td>501</td>
</tr>
<tr>
<td>Plan Type</td>
<td>The Plan is a group health welfare plan providing medical care, prescription drug coverage, dental care, vision care, life, accidental death and dismemberment, weekly accident and sickness, and safety enhancement benefits.</td>
</tr>
<tr>
<td>Plan Year</td>
<td>May 1 – April 30</td>
</tr>
<tr>
<td>Type of Funding</td>
<td>The benefits described in this SPD are self-funded except for Life Insurance and Accidental Death and Dismemberment Insurance benefits, which are currently insured by MetLife.</td>
</tr>
<tr>
<td>Collective Bargaining Agreements</td>
<td>The Plan is established and maintained pursuant to collective bargaining agreements and participation agreements between employers and the Carpenters’ District Council of Greater St. Louis and Vicinity. Contributions are made to the Fund by participating employers for active members. The Plan contains a self-payment provision for underemployed, retired, disabled, and self-employed members and surviving spouses as well as COBRA continuation premiums. Copies of the collective bargaining agreement may be obtained upon written request to the administrator, and are available for examination at: Carpenter’s District Council of Greater St. Louis 1401 Hampton Avenue St. Louis, Missouri 63139 Telephone: 314-644-4800 Toll free: 800-332-7188 <a href="mailto:union@carpdc.org">union@carpdc.org</a></td>
</tr>
<tr>
<td>Agent for Service of Legal Process</td>
<td>Service of Legal Process may be made upon the Plan Administrator, Secretary of the Board of Trustees or an individual Trustee at: Carpenters’ Health and Welfare Trust Fund of St. Louis 1419 Hampton Avenue St. Louis, Missouri 63139</td>
</tr>
</tbody>
</table>
**Amendment of Termination**

The Board of Trustees has the right to amend or terminate the Plan in whole or in part at any time.

**Administrative Service Providers**

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Address</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coventry Health Care of Missouri, Inc. (Coventry)</td>
<td>550 Maryville Center, Suite 300</td>
<td><a href="http://www.chcmissouri.coventryhealthcare.com">www.chcmissouri.coventryhealthcare.com</a></td>
</tr>
<tr>
<td><strong>Mental Health, Substance Abuse Disorder, Member Assistance Program (MAP)</strong></td>
<td></td>
<td><a href="http://www.mbh-eap.com">www.mbh-eap.com</a></td>
</tr>
<tr>
<td>Mercy Managed Behavioral Health</td>
<td>1000 Des Peres Road, Suite 200</td>
<td></td>
</tr>
<tr>
<td>St. Louis, Missouri 63131</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Benefits</strong></td>
<td></td>
<td><a href="http://www.deltadentalmo.com/carpdc">www.deltadentalmo.com/carpdc</a></td>
</tr>
<tr>
<td>Delta Dental of Missouri</td>
<td>P.O. Box 8690</td>
<td></td>
</tr>
<tr>
<td>St. Louis, Missouri 63126</td>
<td></td>
<td><a href="http://www.deltadentalmo.com/carpdc">www.deltadentalmo.com/carpdc</a></td>
</tr>
<tr>
<td><strong>Prescription Drug Benefits</strong></td>
<td></td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
</tr>
<tr>
<td>Express Scripts/Medco</td>
<td>100 Parsons Pond Drive</td>
<td></td>
</tr>
<tr>
<td>Franklin Lakes, New Jersey 07417</td>
<td></td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
</tr>
<tr>
<td>Diplomat Pharmacy</td>
<td>P. O. Box 321130</td>
<td></td>
</tr>
<tr>
<td>Flint, MI 48532</td>
<td></td>
<td><a href="http://diplomat.is/">http://diplomat.is/</a></td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSP</td>
<td>3333 Quality Drive</td>
<td></td>
</tr>
<tr>
<td>Rancho Cordova, California 95670</td>
<td></td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MetLife</td>
<td>Attn: Life Claims Department</td>
<td></td>
</tr>
<tr>
<td>P. O. Box 6115</td>
<td></td>
<td><a href="http://www.metlife.com">www.metlife.com</a></td>
</tr>
<tr>
<td>Utica, New York 13504-6115</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**No Guarantee of Employment**

Your coverage by the Plan does not constitute a guarantee of your continued employment.

**Plan Inspection and QMCSO Procedures**

If you want to inspect or receive copies of additional documents relating to the Plan, contact the Benefit Office. You will be charged a reasonable fee to cover the cost of copying any documents requested. Participants and beneficiaries can obtain from the administrator, without charge, a copy of the Plan’s procedures governing qualified medical child support order determinations.

**Board of Trustees**

The Board of Trustees consists of Employer and Union Trustees. Employer Trustees are appointed by a bargaining agency that represents contributing employers. Union Trustees are appointed by the Carpenters’ District Council.

<table>
<thead>
<tr>
<th>Union Trustees</th>
<th>Employer Trustees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terry Nelson</td>
<td>Renee Bell (Chairperson)</td>
</tr>
<tr>
<td>(Managing Trustee and Secretary)</td>
<td>Waterhout Construction Company</td>
</tr>
<tr>
<td>1401 Hampton Avenue</td>
<td>8110 Dale Avenue</td>
</tr>
<tr>
<td>St. Louis, Missouri 63139</td>
<td>St. Louis, Missouri 63117</td>
</tr>
<tr>
<td>Al Bond</td>
<td>Ken Stricker</td>
</tr>
<tr>
<td>1401 Hampton Avenue</td>
<td>The Jones Company</td>
</tr>
<tr>
<td>St. Louis, Missouri 63139</td>
<td>16440 Chesterfield Grove Road</td>
</tr>
<tr>
<td>Don Brussel</td>
<td>Chesterfield, Missouri 63005</td>
</tr>
<tr>
<td>1401 Hampton Avenue</td>
<td></td>
</tr>
<tr>
<td>St. Louis, Missouri 63139</td>
<td></td>
</tr>
<tr>
<td>Kevin Byrne</td>
<td>Robert Calhoun</td>
</tr>
<tr>
<td>1401 Hampton Avenue</td>
<td>Calhoun Construction Management</td>
</tr>
<tr>
<td>St. Louis, Missouri 63139</td>
<td>6600 W. Main Street (Rear)</td>
</tr>
<tr>
<td>Dennis Joyce</td>
<td>Belleville, Illinois 62223</td>
</tr>
<tr>
<td>8955 E. 38th Terrace</td>
<td></td>
</tr>
<tr>
<td>Kansas City, Missouri 64129</td>
<td></td>
</tr>
<tr>
<td>Kevin Hamilton</td>
<td>Timothy Schoolfield</td>
</tr>
<tr>
<td>1401 Hampton</td>
<td>Country Side Carpets and Interiors, Inc.</td>
</tr>
<tr>
<td>St. Louis, Missouri 63139</td>
<td>1305 Tom Ginnever Ave.</td>
</tr>
<tr>
<td>Mike Smegner</td>
<td>O’Fallon, MO 63366</td>
</tr>
<tr>
<td>Acme Constructors, Inc.</td>
<td>J im Sauer</td>
</tr>
<tr>
<td>7212 Well Avenue</td>
<td>Fixture Contracting Co. Inc.</td>
</tr>
<tr>
<td>St. Louis, Missouri 63119</td>
<td>10630 Midwest Industrial Blvd.</td>
</tr>
<tr>
<td>Scott Bryne</td>
<td>St. Louis, Missouri 63132</td>
</tr>
<tr>
<td>1401 Hampton Avenue</td>
<td></td>
</tr>
<tr>
<td>St. Louis, MO 63139</td>
<td></td>
</tr>
<tr>
<td>James Brennan</td>
<td>James Brennan</td>
</tr>
<tr>
<td>218 Chesterfield Towne Centre</td>
<td>218 Chesterfield Towne Centre</td>
</tr>
<tr>
<td>Chesterfield, MO 63005</td>
<td></td>
</tr>
</tbody>
</table>
Rescission

The Plan will not rescind health coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage for health benefits that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance has only a prospective effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. Retroactive elimination of coverage back to the date of termination of employment is not a rescission if due to a delay in administrative recordkeeping if the employee does not pay any premiums for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactive to the date of divorce.

The Plan is required to provide at least 30 days advance written notice to each participant who is affected by a rescission of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group. Retroactive termination of coverage in cases of an unreported divorce or failure to timely pay premiums is not an Affordable Care Act rescission and, therefore, the 30-day advance notice requirement does not apply.

Discretionary Authority

The Trustees have the power and authority to amend or terminate the Plan, to increase, decrease, or change benefits and premiums, or change eligibility rules or other provisions of the Plan of Benefits for the Gold or Platinum Medical Plans, in their discretion as may be proper or necessary for the sound and efficient administration of the Fund, provided that such changes are not inconsistent with law or with the provisions of this Plan or with the provisions of the Trust Agreement.

The Trustees and other Plan fiduciaries and individuals, to whom responsibility for the administration of the Plan has been delegated, have the full discretionary authority available under applicable law to construe the trust agreement, Summary Plan Description, the Plan, the Plan documents and related documents including but not limited to collective bargaining agreements, participation agreements and reciprocity agreements, and the procedures of this Fund, to interpret any facts relevant to such construction. This authority extends to every aspect of their administration of the Plan including benefit determinations, eligibility determinations and entitlement to Plan benefits. Any interpretation or determination made under this discretionary authority will be given full force and effect and will be accorded judicial deference, unless it can be shown that the interpretation or determination was arbitrary and capricious. Benefits under the Plan will be paid only if the Trustees (or other Plan fiduciaries, such as a third party Claims Fiduciary) decide in their discretion that the claimant is entitled to them. In addition, any interpretation or determination made pursuant to this discretionary authority is binding on all involved parties.
Plan Amendment and Plan Termination

The Plan may be amended or terminated by the Trustees in accordance with the terms of the Trust Agreement and the applicable collective bargaining agreements. In the event the Plan is terminated, any remaining funds will be used for benefits until the funds are exhausted. The Trustees reserve the right to amend or terminate this Plan at any time and in any manner, subject to the terms of any collective bargaining agreement or insurance policy pursuant to which Plan benefits are provided. In the event of a termination of the Trust, all liabilities of the Plan shall be satisfied to the extent and as provided by the Trust Agreement, insurance policy or other agreement with an insurer, third party administrator or other entity, and any applicable law, provided, however, that any Plan amendment or termination may be limited by the terms of any insurance policy or agreement with a third party underlying or funding a benefit of this Plan. Amendments to the Plan shall be adopted by action of the Trustees at a regular or special meeting of the Trustees, and shall be recorded in the minutes of such meeting, or in a formal document executed by the Trustees as an amendment to the Plan documents. Any such amendment to the Plan shall become effective upon adoption, or if a different effective date is specified by the Trustees, on such specified date. If an amendment to the Plan is recorded in minutes of the meeting at which it is adopted, the amendment shall be given effect as recorded in the minutes. If such amendment to the Plan is thereafter incorporated in a formal document executed by the Trustees as an amendment to the Plan document, the provisions of the formal document shall, upon execution, supersede the provisions of the meeting minutes with respect to such amendment to the Plan.

Furnishing Required Information and Documentation

Every covered person shall, upon reasonable request, furnish the Board of Trustees such information or proof as may be reasonably necessary or helpful in determining eligibility or benefit payments. Failure on the part of the covered person to comply with any request for information shall be grounds for denying or discontinuing benefits to such covered person until the request is complied with. If any covered person knowingly makes any false statement concerning any fact material to his claims for benefits, the Board of Trustees shall have the right to recover any payment made to such person in reliance on such false statements.

ERISA Rights

As a participant in the Carpenter’s Health and Welfare Trust Fund of St. Louis, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Benefit Office, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The Fund Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Fund’s annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.
Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants.

No one, including your employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and if you do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or:

The Division of Technical Assistance and Inquiries

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
This glossary is provided to help you better understand the Plan by summarizing some of its important terms. Unless indicated otherwise in a specific context, words used in this Summary Plan Description have the meanings as listed below (and additional definitions can be found within the main text). Whenever required within 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. However, any questions about Plan coverage that concern these terms will be answered not just by representatives of the Plan but also by the Plan’s network sponsors, who have the authority to use their own procedures and expertise to define these terms.

**abortion:** the termination of pregnancy before the fetus reached the stage of viability.

**alternate facility:** a non-hospital health care facility or an attached facility designated as such by a hospital and providing 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:

- Scheduled surgical services;
- Emergency health services
- Urgent care services, or prescheduled rehabilitative services;
- Laboratory or diagnostic services.

**alternate recipient:** the child or children identified in a Qualified Medical Child Support Order as being eligible to receive health care coverage pursuant to the Qualified Medical Child Support Order.

**ambulatory surgical center:** a facility operated primarily for performing surgical procedures under the supervision of a staff of physicians and that meets all of the following conditions:

- It requires a licensed anesthesiologist to administer anesthesia and remain present during surgical procedures.
- It provides at least two operating rooms and one post-operative recovery room.
- It has X-ray and laboratory equipment.
- It maintains written agreements with a hospital or hospitals concerning immediate admittance of patients who develop complications.

- It maintains adequate medical records for each patient.
- The facility does not provide accommodations for overnight stay.

**appeal:** a request by you or your authorized representative for consideration of an adverse benefit determination of a health service request or benefit that you believe you are entitled to receive or have coverage for.

**benefit quarter:** any of the three-month periods beginning January 1, April 1, July 1 and October 1 of each year.

**Carpenters’ Pension Plan:** refers to the Pension Plan of the Carpenters’ Pension Trust Fund of St. Louis, the Kansas City Pension Plan, the Kansas Building Trades (KBT) or Geneva.

**coinsurance:** the percentage of an allowed amount the Plan will pay for a service or supply as defined in the benefit schedule.

**contribution quarter:** any of the three-month periods beginning February 1, May 1, August 1, and November 1 of each year.

**copayment or copay:** a specified fixed dollar amount that you must pay as a condition of the receipt of certain services as provided in the Plan.

**covered charge or covered expense:** refers to the expense incurred by a covered person for medical care, services or supplies that:

- are prescribed by a physician and are necessary in connection with the therapeutic treatment of the injury or sickness involved,
- are listed as covered charges and are not excluded from payment of benefits by any exclusions and limitations of the Plan,
- are recognized as generally accepted medical practice, and
- are not in excess of the reasonable and customary charges for the same or similar medical care, services, and supplies.

**covered person:** refers to a member or a member’s eligible dependent who is eligible for benefits under the Plan in accordance with the Eligibility and Enrollment section of this document.
creditable hour: an hour of work reported by your employer and for which contributions have been made by your employer to the Health and Welfare Trust Fund. A creditable hour also includes an hour for which you perform picket duty for the Carpenters’ District Council or its constituent locals and for which contributions have been received on your behalf. However, with respect to benefit determination for the Weekly Accident and Sickness Benefits of this Plan, hours received and paid for as a result of picket duty (referred to as picket hours) will not qualify as creditable hours.

custodial care: care that is primarily for the purpose of helping the patient with activities of daily living or meeting personal needs and that can be provided safely and reasonably by people without professional skills or training. The term includes such other care that is provided to an individual who, in the opinion of the medical director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized person, who cannot reasonably be expected to live outside of an institution. Examples of custodial care are rest cures, respite care, and home care, which can be provided by family members or private duty caregivers.

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

devolutional therapy: therapy designed to further growth or bring about improvement by gradual training adapted to the covered person’s physical and mental development.

durable medical equipment (DME): equipment that meets all of the following conditions:
- can withstand repeated use.
- is primarily and customarily used in the therapeutic treatment of sickness or injury.
- is generally not useful to a person in the absence of a sickness or injury.
- is appropriate for use in the home.
- is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.
- is not primarily for the convenience of the person caring for the patient.
- is not used for exercise or training.
- is made and used externally to the human body for the therapeutic treatment of an injury or sickness.

educational therapy: therapy intended to further or promote the covered person’s education or intended to educate the covered person.

eligible for Medicare: refers to an individual who is eligible to enroll and participate in the Medicare program by reason of attained age and/or entitlement to Social Security benefits.

emergency: an illness, injury, symptom or condition that is severe enough (including severe pain), that if the patient does not get immediate medical attention it would be reasonable to expect one of the following to result: 1) The patient’s health would be put in serious danger; or 2) The patient would have serious problems with bodily functions; or 3) The patient would have serious damage to any body part or organ.

Enrollment/Change Form: the required application for enrollment in the Plan.

entitled to Medicare: refers to an individual who is both eligible for Medicare and enrolled in any part of Medicare.


exempt: with respect to the spousal coverage program, means a member’s spouse who is not qualified to enroll in health plan coverage through their own employer or a member’s spouse who is not employed.

experimental or investigative: refers to a drug, device, treatment or procedure that:
- 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
- with respect to the illness being treated, the drug or device used in conjunction with a procedure that is not considered to be the standard of care; or
- with respect to clinical trials, for any clinical trial that does not meet the stated criteria; any non-health care service required in conjunction with the clinical trial; or
- 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
• with respect to the illness being treated, reliable evidence shows that 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; or

• “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.

• For purposes of this Plan, clinical trials expressly covered by the Medical Benefit are not considered experimental or investigative.

home health agency: a public or private agency or organization, or subdivision thereof, that:

• is primarily engaged in providing skilled nursing and other therapeutic services,

• has policies established by associated professional personnel, including one or more physicians and one or more registered nurses (RN), to govern the services provided under the supervision of such a physician or nurse,

• maintains medical records on all patients, and

• in cases where applicable state or local law provides for licensing of agencies or organizations of this nature, the latter are licensed or approved by the state or local law as meeting the standards established for such licensing.

hospice agency: a public or private agency or organization that administers and provides hospice care and is either:

• licensed or certified as such by the state in which it is located,

• certified (or is qualified and could be certified) to participate as such under Medicare,

• accredited as such by the Joint Commission on the Accreditation of Health Care Organizations, or

• in compliance with the standards established by the National Hospice Organization.

hospice care program: a coordinated, interdisciplinary program to meet the physical, psychological and social needs of terminally ill persons (defined as those with a 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 sickness or bereavement.

hospital: a legally operated institution that meets one of the following requirements:

• 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:

• general inpatient care and treatment of sickness or injury through medical, diagnostic and major surgical facilities on its premises, or

• Specialized treatment for mental and nervous disorders.

• It is an approved nonresidential chemical dependency treatment center licensed by the jurisdiction (state, District of Columbia, territory, or possession of the United States, or province of Canada) in which it is domiciled, and is providing outpatient treatment to a covered person.
in-network or network provider: the hospitals, physicians, suppliers, ancillary providers and other clinical facilities, pharmacies and vision care providers who have a written agreement with the network sponsor to provide health care services and supplies to plan participants for a negotiated charge at the time the service or supply is provided. You may contact the network at any time to determine a provider’s participation status. An in-network provider may be part of a regional network or a national network with which the Plan has contracted through a third party.

infertility services: those Health Services designed for the primary purpose of successfully fostering and achieving conception and Pregnancy.

injectable: a prescription medication injected by or under the direct supervision of a physician.

injury: a non-occupational bodily injury caused directly and exclusively by external means with respect to which benefits are not payable under any workers’ compensation, occupational disease or similar law.

Inside Eligibility class: a class of eligibility obtained and continued as a result of employment under a collective bargaining agreement where health and welfare hours reported and paid are limited to a maximum of 133 hours per month.

maintenance therapy: rehabilitative services and associated expenses designed primarily to be long-term with no significant medical improvement to the patient begin reasonably expected as determined by the provider or medical director.

medical care management: services provided by the Plan to assist members and their families to receive medical care, services and supplies in the event of a catastrophic sickness or injury.

medically necessary or medical necessity or medically appropriate: those services, supplies, equipment, and facility charges that are not expressly excluded under the Plan and are determined to the Plan to be:

- medically appropriate, so that expected health benefits (such as, but not limited to, increase life expectancy, improved fictional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- necessary to meet your health needs, improve physiological function and required for a reason other than improving appearance;

- rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;
- consistent with the diagnosis of the condition at issue;
- required for reasons other than your comfort or the comfort and convenience of your physician; and
- not experimental or investigational as determined by the Plan.

Medicare: the federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD); designated as the Health Insurance for the Aged Program under Title XVIII of the Social Security Act.

member: an individual who is eligible for benefits, and not covered solely as a dependent, and whose eligibility for benefits results from employment or former employment in which employer contributions were made to the Plan on behalf of such individual.

network sponsor: a provider network the Plan has contracted with to provide access to their provider network services and for other administrative services such as utilization review.

non-active classification: refers to the following classes of individuals:

- Retired members
- Retired self-employed members
- Non-pension members
- Disabled members
- Surviving spouses

non-bargained office employee: any employee of a contributing employer who executes a Participation Agreement For Non-Bargained Office Employees and is accepted by the Trustees, other than:

- An employee covered by a collective bargaining agreement requiring contributions to this Plan or another health and welfare plan, or
- Partner or sole proprietor of the employer and any other person who is prohibited by law from participating in this Plan.
**non-pension member**: a member who is not eligible to participate in the Carpenters’ Pension Plan, but is eligible to participate in the Health and Welfare Plan due to a specific agreement with the Carpenters’ District Council, like a participation agreement or a collective bargaining agreement.

**occupational therapy**: the use of work-related skills to treat or train the covered person, to prevent disability, and to restore the covered person to health, social or economic independence.

**Outside Eligibility class**: an active class of eligibility obtained and continued as a result of employment under a collective bargaining agreement where all hours worked are reported and paid on.

**out-of-network or non-network**: a health care provider who is not contracted with one of the Plan’s network sponsors.

**part-time**: refers to an employee who works, on average, less than 30 hours per week.

**pharmacy benefit manager (PBM) and network sponsor**: the organization with whom the Carpenters’ Health and Welfare Trust Fund has contracted with to administer the Prescription Drug Benefit.

**physical therapy**: the rehabilitation concerned with restoration of function and prevention of disability following sickness 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.

**physician**: only a legally qualified doctor of medicine (MD) or doctor of osteopathy (DO). The term physician also includes a licensed clinical psychologist, a licensed doctor of chiropractic (DC), a doctor of podiatric medicine (DPM), a doctor of dental surgery (DDS), a licensed doctor of medical dentistry (DMD), a licensed doctor of optometry (OD) and a licensed physician assistant (PA), 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.

**Plan year**: the 12-month period from May 1 of one year through April 30 of the succeeding year.

**pre-service claim appeal**: an appeal for which an adverse benefit determination has been rendered for a service that has not yet been provided or requires prior authorization.

**premium**: the monthly fee required for coverage under certain classes of coverage under the Plan.

**primary care physician (PCP)**: 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.

**prior authorization**: also referred to as pre-certification, the review and approval of requests for certain services or supplies under the Plan. Services that require prior authorization are reviewed by a team of medical professionals prior to receipt of such services and supplies to determine medical necessity and that the services meet the standard of care.

**provider**: a physician, hospital, or other provider of medical care, services or supplies. All providers must be licensed to provide services within the scope of their license by the state in which the services are rendered.

**Qualified Medical Child Support Order (QMCSO)**: an 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 member 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:

- provides for child support with respect to a member’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
- is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

**self-employed**: under the spousal coverage program, refers to an individual doing business as a sole-proprietor or partner, who either has no employees or offers no health coverage to employees.

**self-injectable**: medication that is injected by the patient or patient’s caregiver.
**semi-private accommodations**: a room in a hospital or covered inpatient facility with two or more beds. The difference in cost between semi-private accommodations and private accommodations is covered only when private accommodations are medically necessary or when semi-private accommodations are not available, and when an exception has been made by the medical director in advance of the admission. Exceptions may or may not be granted by the Plan.

**sickness or illness**: a non-occupational bodily disorder, disease, mental infirmity or pregnancy with respect to which benefits are not payable under any workers’ compensation, occupational disease or similar law. All sicknesses that are due to the same or related cause or causes will be deemed one sickness.

**skilled nursing facility**: a legally operated institution that:

- specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis and is certified by Medicare,
- maintains on the premises specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis,
- maintains on the premises all facilities necessary for medical treatment,
- 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,
- is under 24-hour supervision of a physician or registered graduate nurse (RN),
- keeps adequate daily medical records for each patient,
- if not operated by a physician, has the services of one available under an established agreement, and
- is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, drug addicts, alcoholics, or a facility for custodial care, remedial education or training.

**Special Participation Eligibility class**: a class of eligibility obtained and continued as a result of employment under an office employee participation agreement or self-employed contract requiring fixed monthly contributions to the Plan.

**speech therapy**: the remediation or rehabilitation for speech and language impairments.

**spousal coverage program**: a plan provision requiring spouses who have access to employer-paid or partially paid health coverage through their employers to enroll in that coverage in order to be covered under this Plan as secondary.

**total disability**: complete inability of the member to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the member 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 member.

**Trust Agreement**: the Carpenters’ Health and Welfare Trust Fund Agreement of May 1, 1953, as restated December 11, 1975 and as further amended from time to time.

**Trust Fund or Fund**: the Fund established under the Trust Agreement that will receive contributions and from which any amounts payable under the Plan are to be paid.

**Trustees**: the Trustees under the Trust Agreement.

**Union**: Union as defined in the Carpenters’ Health and Welfare Trust Fund Agreement.

**urgent care claim appeal**: an appeal that must be reviewed under an expedited appeal process because the application of non-urgent care appeal time frames could seriously jeopardize:

- the life or health of the member;
- the member’s ability to regain maximum function.

In determining whether an appeal involves urgent care, the Plan must apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

An urgent care appeal also is an appeal involving care that the treating physician deems urgent in nature; or an appeal where the treating physician determines that a delay in the care would subject the member to severe pain that could not be adequately managed without the care or treatment being requested.