



Carpenters' Health & Welfare Trust Fund of St. Louis

# Plan Document

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## Section I

### Eligibility & Enrollment

This Section I set forth the rules for determining eligibility for all benefits under this Plan except Safety Enhancement Benefits under Section VIII. In addition, eligibility for Life and Accidental Death and Dismemberment Insurance is subject to additional limitations set forth in Section VIII.

#### A. Eligible Employees

An employee covered by a collective bargaining agreement requiring contributions to the Carpenters' Health and Welfare Trust Fund of St. Louis may become eligible for benefits ("covered") as a Member of the Plan. Employees eligible to become Members also include:

1. Employees of:
  - a. The Carpenters' District Council of Greater St. Louis and Vicinity;
  - b. Benefit Funds sponsored by the District Council; and
  - c. Any other Employer obligated by written agreement to make contributions to the Fund on behalf of such employees and who is accepted by the Trustees.
2. Retired employees for whom the District Council was the recognized bargaining representative when they were actively working, or who were employees described in paragraph 1 above.
3. Members of a Special Participation Group, including:
  - a. Non-Bargained Office Employees of Contributing Employers, if each of the following conditions is met:
    - 1) The Employer must be obligated to contribute and be contributing for one or more employees covered by a collective bargaining agreement;
    - 2) The Employer must execute a participation agreement for Non-Bargained Office Employee coverage on terms acceptable to the Trustees;
    - 3) The Employer must be accepted by the Trustees in their discretion;
    - 4) The Employer must agree to contribute, at the times and monthly rates established by the Trustees from time to time, on behalf of all of the Employer's non-collectively bargained employees who work (in an office or elsewhere) 30 hours per week or an average of 130 hours or more per month as defined in Section 4980H(c)(4) of the IRS code, and at the Employer's option, may also agree to contribute for all such employees who work less than 30 hours. Non-Bargained Office Employee coverage for any or all Employers may be terminated by the Trustees at any time.
  - b. Other groups of employees for whom contributions are made on a month-to-month basis under agreements acceptable to the Trustees.

#### B. Initial Enrollment and Change in Circumstances

All new Members in every classification must complete an Enrollment/Change Form accepted by the Plan before any benefits under this Plan will be paid.

In addition, all Members must complete and file an Enrollment/Change Form accepted by the Plan upon the Member's marriage, legal separation, divorce, birth or adoption of a child, or if the Member or a Dependent becomes covered under another health plan (medical, prescription, dental, or vision).

The Plan may require documentation, such as birth certificates and marriage licenses, as proof of the eligibility of Dependents. 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.

## C. Eligibility Classifications

### 1. Active Classification

A Member is in the Active Classification if the Member's eligibility results from:

- a. Employer contributions for the Member's Active Work, or
- b. The Member's Minimum or Difference self-payments, or
- c. The Member's COBRA self-payments following a period of Active coverage, while the Member is not Eligible for Medicare.

### 2. Eligibility Classes within the Active Classification

There are three Eligibility Classes under the Active Classification:

- a. **Outside Eligibility** composed of Members who are employed in work covered by a collective bargaining agreement or participation agreement requiring contributions to this Plan for all hours of work.
- b. **Inside Eligibility**, composed of Members who are 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.
- c. **Special Participation Eligibility** composed of Members of a Special Participation Group.

## D. Initial Eligibility of Active Members

### 1. Outside Eligibility

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.

### 2. Inside Eligibility

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.

### 3. Special Participation Eligibility

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 behalf of that employee.

## E. Continuing Eligibility – Active Members

### 1. Outside and Inside Eligibility

A Member who has established Outside or Inside Eligibility 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:

<i>CONTRIBUTION QUARTER</i> Hours Worked	Provides Coverage For	<i>BENEFIT QUARTER</i> Eligibility Period
August, September, October	→	January, February, March
November, December, January	→	April, May, June
February, March, April	→	July, August, September
May, June, July	→	October, November, December

- a. **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.
- b. **Look Back Rule:** A Member who worked at least 1,200 Credit Hours during a 12 consecutive-month period ending with any month in a Contribution Quarter, will have eligibility extended through the Benefit Quarter that next follows that Contribution Quarter. Continuation of eligibility under this provision is conditioned on the Member remaining eligible for employment in Covered Employment.

## 2. Outside Eligibility Only

**Plan Year Rule:** A Member in the Outside Eligibility Class who worked at least 1,300 Credit Hours in a Plan Year, will have eligibility extended until the end of the third full Benefit Quarter that next follows the end of that Plan Year. Continuation of eligibility under this provision is conditioned on the Member remaining Eligible for Employment in Covered Employment.

## 3. Extension of Outside and Inside Eligibility for Disability

Generally, coverage in the Outside or Inside Eligibility Class will end if a Member fails to qualify under at least one of the above provisions and does not elect an available self-payment option. 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 ending with the month in which the disability began, the Member's eligibility in the Outside or Inside Eligibility Class will be automatically continued, without contributions, until the earlier of:

- a. The date the disability ends, or
- b. The last day of the Benefit Quarter containing the first anniversary of the date the disability began.

## 4. 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.

## F. Termination of Active Eligibility

Unless an Active Member elects an available self-payment option, the Member's coverage will end on the earliest of the following dates:

1. The last day of eligibility earned by the Member's Credit Hours.
2. The date of the Member's death.
3. The date the Member falsifies any information in connection with a claim for benefits, or commits any action with the intent to defraud the Plan.
4. The date the Plan terminates.

In addition, an Active Member's eligibility for benefits in the Plan will end on the date when the Member is Eligible for Medicare coverage that would be primary to this Plan, but is not enrolled in both Parts A and B of Medicare. An Active Member's Medicare coverage is primary to this Plan if the Member is employed by a "small Employer" within the meaning of the Medicare regulations, or if the Member has had 30 months of Medicare coverage on account of End-Stage Renal Disease.

Eligibility of a Member that would otherwise terminate pursuant to the foregoing termination provisions will nevertheless continue to the extent required under the terms and conditions of the Family and Medical Leave Act of 1993 and the Uniformed Services Employment and Reemployment Rights Act of 1994. If a Covered Person becomes absent from employment by reason of service in the Uniformed Services, and would otherwise lose coverage on account of such absence, he or she may elect to continue coverage in the Plan as provided in 38 USC section 4317(a).

## **G. Reinstatement Provisions – Active Members**

### **1. Outside and Inside Eligibility Class**

A Member who has lost coverage in the Outside or Inside Eligibility Class, and who is not participating as a self-pay Member in the Non-Active Classification, may reinstate the lost Active coverage by working the same number Credit Hours in a Contribution Quarter as are required for continuing eligibility under Subsection E above, provided that these Credit Hours are worked within one year of the Member's termination date. The reinstated coverage becomes effective on the first day of the next Benefit Quarter.

A Member who has lost coverage in the Outside or Inside Eligibility Class, who does not qualify for reinstated coverage under the previous paragraph, must again satisfy the initial eligibility requirements to regain Active coverage.

### **2. Special Participation Eligibility Class**

A Member who has lost coverage in the Special Participation Eligibility Class may reinstate the lost coverage only if the Member's Employer makes a timely contribution for such Member and the Employer's employees then qualify as a Special Participation Group. The Member's coverage in the Special Participation Eligibility Class will be reinstated on the first day of the month following the month in which the contribution is received by the Plan.

## **H. Self-Payment Provisions – Active Members**

A Member who would otherwise lose coverage in the Outside or Inside Eligibility Class because of insufficient Credit Hours, and who is not drawing a Normal, Supplemental, Deferred or Disability Pension under the Carpenters' Pension Plan, may maintain continuous coverage for a limited period of time by electing either Minimum/Difference self-payments or COBRA continuation coverage. These options are mutually exclusive, and an election of one is a waiver of the other with respect to that loss of coverage. Election of either option does not prevent the Member from regaining Active coverage through Credit Hours under the provisions of Subsections E and G above.

A Member who would otherwise lose coverage in the Special Participation Eligibility Class may maintain continuous coverage for a limited period of time only by electing COBRA. The Minimum/Difference self-payment option is not available to Members in this eligibility class or for Members not eligible for employment with a contractor who is signatory to a labor contract with the Carpenters' District Council or Greater St. Louis and Vicinity.

### **1. Minimum/Difference Self-Payments**

If a Member described in the first paragraph of this Subsection H has earned less than 300 Credit Hours in a Contribution Quarter, and for that reason would otherwise lose Active eligibility in the corresponding Benefit Quarter, the Member may elect to maintain continuous Active eligibility by making self-payments directly to the Fund (Minimum/Difference payments). If a Member makes a timely Minimum/Difference payment for a Benefit Quarter in the required amount, the Member's eligibility will be extended through that Benefit Quarter.

The required amount of a Member's Minimum/Difference payment for a Benefit Quarter is equal to the difference between 300 and the number of Credit Hours actually earned by the Member in the corresponding Contribution Quarter, multiplied by the current hourly Employer contribution specified in the labor agreement under which most contributions are paid. If no Credit Hours were earned, the payment amount is equal to the Employer contribution required for the minimum 300 Credit Hours.

Coverage maintained by Minimum/Difference payments must be continuous, beginning with the first Contribution Quarter in which a Member has earned less than 300 Credit Hours. A Member may maintain Active coverage by Minimum/Difference payments for no more than eight consecutive Benefit Quarters (24 months), except that a Member may maintain coverage for up to four additional quarters by making Minimum/Difference payments based on a minimum of 400 Credit Hours per Contribution Quarter, rather than 300.

Election of Minimum/Difference payments is an alternative to election of COBRA. COBRA continuation coverage is not available to a Member who loses coverage at the end of one or more quarters of Minimum/Difference payments. If a Member exhausts the maximum permissible period of coverage by making Minimum/Difference payments, the Member can regain Active coverage only by satisfying the continuation or reinstatement requirements of Subsections E or G above. Alternatively, coverage may be maintained in the Non-Active Classification if the Member qualifies.

A Member who ends a period of coverage maintained by Minimum/Difference payments may not begin a new period of coverage maintained by Minimum/Difference payments until the Member has at least two consecutive quarters of Active coverage earned solely with Credit Hours.

A Minimum/Difference payment for a Benefit Quarter may be paid in one payment for the entire quarter of coverage or, at the Member's option, may be paid in monthly installments. If paid quarterly, the payment is due on the first day of the month prior to the applicable Benefit Quarter, and 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:

BENEFIT QUARTER FOR COVERAGE	PAYMENT DUE
January, February, March	December 1
April, May, June	March 1
July, August, September	June 1
October, November, December	September 1

If paid monthly, the amount due each month is one-third of the total payment due for the Benefit Quarter. Monthly payments are due on the first day of the month prior to the applicable month of coverage, and must be received by the Fund within 15 days of the due date to be accepted. If a monthly payment is not made within the time for acceptance, coverage will end on the last day of the month for which coverage has been paid. The payment schedule for monthly payments is shown on the following table:

MONTH OF COVERAGE	PAYMENT DUE
First Quarter: January	December 1
February	January 1
March	February 1
Second Quarter: April	March 1
May	April 1
June	May 1
Third Quarter: July	June 1
August	July 1
September	August 1
Fourth Quarter: October	September 1
November	October 1
December	November 1

## 2. COBRA Self-Payments

An Active Member in any of the Eligibility Classes who would otherwise lose coverage (and, in the case of a Member in the Outside or Inside Eligibility Classes, has not elected Minimum/Difference payments) may elect COBRA continuation coverage under the terms and conditions set forth in Subsection K below. COBRA coverage that begins immediately following a period of Active coverage is considered a continuation of Active coverage for purposes of the Plan, unless otherwise provided.

### I. Non-Active Classification

The Non-Active Classification allows qualified Members and their Dependents to continue coverage under the Plan through self-payments, after they no longer meet the requirements of the Active Classification. To be eligible for coverage in the Non-Active Classification, an individual must have previously been an Active Member in the Outside or Inside Eligibility Class (or must be a Dependent of such Member), qualified within one of the following five categories:

- Retired Members
- Non-Pension Members
- Retired Self-Employed Members
- Disabled Members
- Surviving Spouses

#### 1. Non-Active Benefits

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

##### a. Non-Active Plan Benefits for Medicare-Eligible Individuals

If an individual Member or Dependent covered in the Non-Active Classification becomes Eligible for Medicare, that individual will cease to be eligible for any benefit from the Plan. If, upon becoming Eligible for Medicare, such individual elects to enroll immediately in the UHC Medicare Advantage Program described in Subsection I.3 below, the individual will remain eligible, while enrolled in the UHC Medicare Advantage Program, for the Plan's Life and Accidental Death benefit, and will also have the option to remain eligible for the Plan's Dental benefits at an increased Premium, while so enrolled. If a Member thus enrolls in the UHC Medicare Advantage Program, the Member will also have the option, while enrolled in such Medicare Advantage program, to maintain family coverage in the Non-Active Classification for his or her Dependents, by payment of the applicable Premium.

##### b. Short Term Disability Benefits

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

##### c. Dental Benefits

Members covered in the Non-Active Classification, and Members or Dependents enrolled in the UHC Medicare Advantage Program, have the option whether to purchase the Dental benefits of the Plan at a Premium higher than the Premium applicable without Dental benefits. Such persons must enroll for optional Dental benefits at the time they first enroll in the Non-Active Classification, or in the UHC Medicare Advantage program, respectively; otherwise must wait for the next Open Enrollment period of October 1 through December 15. If the Dental benefit is dropped after having been elected, it may not be reinstated.

##### d. Dependent Coverage

Members covered in the Non-Active Classification have the option whether to purchase 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 a Non-Active Member may change to family coverage

- 1) as permitted under Subsection 11 below in the course of reinstatement of Non-Active coverage after a gap; or
- 2) by applying for family coverage within 30 days after a dependent of the Member becomes entitled to a special enrollment period under the provisions of 29 CFR 2590.701-6.

## **2. Self Payment Provisions**

Coverage of Members and Dependents in the Non-Active Classification requires self-payment of a monthly contribution (Premium) directly to the Fund, as determined and published periodically by the Trustees. Contribution amounts vary under each category depending upon the coverage selection and length of service in the Plan.

Monthly contributions for coverage under the Non-Active Classification are due on the first day of the month prior to the month of coverage and must be received in the Plan Office within 15 days of the due date to be accepted.

Monthly contributions for individuals participating in the UHC Medicare Advantage Program are due on the first day of the month prior to the month of coverage and must be received in the Plan Office within 15 days of the due date to be accepted.

## **3. UHC Group Medicare Advantage Program**

As stated in Subsection 1.a. above, a Member or Dependent who becomes Eligible for Medicare while covered in the Non-Active Classification ceases to be eligible for Plan benefits if no further action is taken. To assist such individuals' transition to Medicare, the Plan has arranged for United Health Care to offer the UHC Medicare Advantage Program, at Premium rates and with benefits that may be attractive. The UHC Medicare Advantage Program is a group or group-type insurance program offered by an insurer to provide Medicare Part C benefits, and is available only to individuals who become Eligible for Medicare while covered in the Plan's Non-Active Classification.

Benefits provided in the UHC Medicare Advantage Program are not Plan benefits; they are provided independently under an insurance contract in return for the Premium charged by United Health Care. The role of the Plan is to collect and remit monthly Premiums to United Health Care on behalf of individuals who choose to participate, and to report to United Health Care the individuals who have paid such Premiums. The Plan's monthly charge for an individual who participates in the UHC Medicare Advantage Program includes 100% of the Premium due from the individual to United Health Care, plus an administrative fee for the Plan's services, plus the Plan's own Premium for Life and Accidental Death and Dismemberment benefits, and for optional Dental and Dependent benefits, if elected.

The Plan does not endorse the UHC Medicare Advantage Program, or pay any part of its cost, or require its use. Participation in the UHC Medicare Advantage Program is strictly voluntary, at the option of an individual who becomes Eligible for Medicare while covered in the Plan's Non-Active Classification. Such an individual may instead choose only conventional Medicare (Parts A and B), or Medicare plus private supplemental insurance, or a different Medicare Advantage plan. However, enrollment in a different Medicare Advantage plan, or in Medicare Part D, will preclude or terminate participation in the UHC Medicare Advantage Program.

To participate in the UHC Medicare Advantage Program, an individual must also be enrolled in Medicare Parts A and B, and must enroll in the UHC Medicare Advantage Program, either prior to their Medicare Effective date or no later than 60 days after first becoming Eligible for Medicare, to be accepted. An election to maintain optional benefits under the Plan must be made at the same time. A Member's Dependent may participate in the UHC Medicare Advantage Program only if, and so long as, (1) the Member has elected family coverage; (2) the Member is covered in the Non-Active Classification before becoming Eligible for Medicare; and (3) the Member is enrolled in the UHC Medicare Advantage Program after becoming Eligible for Medicare. An individual whose participation in the UHC Medicare Advantage Program has terminated has a one-time only option to re-enroll by establishing coverage in the

Non-Active Classification after a gap, in accordance with Subsection 11 below. Refer to Non-Active Eligibility After a Gap in Coverage (Reinstatement) on page 21.

A Member or Dependent, while covered in the Active Classification, does not lose Plan eligibility on account of becoming Eligible for Medicare, and is not eligible to enroll in the UHC Medicare Advantage Program unless and until becoming covered in the Non-Active Classification.

#### **4. Retired Members**

For purposes of eligibility for retiree coverage in the Non-Active Classification, a Member “retires” at the time the Member begins to receive pension benefits from any of the following Carpenters’ Pension Plans: St. Louis, Kansas City, Kansas Building Trades, or Geneva. A Member is eligible for retiree coverage in the Non-Active Classification on 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 of Subsection 5 below for Self-Employed and Non-Pension Members.

An Active Member who retires while covered in the Outside or Inside Eligibility Class is eligible for retiree Non-Active coverage of the Member or, for additional Premium, coverage of the Member and the Member’s Dependents. To achieve continuous coverage, such a Member must enroll for retiree coverage by the first day of the month following the month in which the Member’s Active coverage ends. A Member who retires with a Normal, Supplemental, Deferred or Disability Pension while covered by Minimum/Difference payments may not extend the period of Active coverage by making an additional Minimum/Difference payment after retirement. A Member who retires while covered by COBRA may extend the period of Active coverage until the end of the applicable COBRA period.

#### **5. Retired Self-Employed Members & Non-Pension Members**

- a. Self-Employed Members who are not eligible to receive a pension from the Carpenters’ Pension Plan nevertheless qualify for retiree coverage in this Plan in the Non-Active Classification if the following conditions are satisfied:
  - 1) The Self-Employed Member must have attained age 62;
  - 2) The Self-Employed Member must have ceased working; and
  - 3) The Self-Employed Member must have been covered by the Plan as an Active Member in the Outside or Inside Eligibility Class for the five consecutive years preceding enrollment for retiree coverage.
- b. 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. A Non-Pension Member qualifies for retiree coverage in this Plan in the Non-Active Classification if all of the following conditions are satisfied:
  - 1) The Non-Pension Member must have permanently ceased all employment, and so inform the Plan in writing.
  - 2) The Non-Pension Member must be covered in the Outside or Inside Eligibility Class immediately before beginning retiree coverage.
  - 3) The Non-Pension Member must enroll for retiree coverage beginning on the first day of the month following the last day of eligibility in the Active Classification, or if earlier, the first day of the month in which the Member ceased employment.

#### **6. Disabled Members**

An Active Member who becomes totally disabled while covered in the Outside or Inside Eligibility Class qualifies for coverage in this Plan in the Non-Active Classification during such disability if all of the following conditions are satisfied:

- a. The Member must provide medical evidence of Total Disability satisfactory to the Trustees. For purposes of this eligibility provision, Total Disability means that the Member is prevented, due solely to a Sickness or Injury, from engaging in any of the usual activities of his or her specific, customary occupation.

- b. The Member must provide such evidence to the Trustees as soon as reasonably possible after it becomes available to the Member.
- c. The Member must enroll in Non-Active disability coverage beginning on the first day of the month following the last day of eligibility in the Active Classification.
- d. The Member must provide medical evidence of the continuation of Total Disability as often as requested by the Plan.

Non-Active disability coverage will terminate if a Member is no longer totally disabled.

## **7. 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 is affiliated Locals at all times to be eligible for Non-Active coverage.

## **8. Surviving Spouse**

In the event of a Member's death, while covered in the Active or Non-Active Classification, in any class except the Special Participation Eligibility Class, if the Member's spouse was covered as a Dependent at the time of the Member's death, the surviving spouse qualifies for surviving spouse coverage in the Non-Active Classification while living, but not after the date (if any) on which the surviving spouse remarries. To obtain this coverage, the surviving spouse must enroll no later than 30 days after termination of the surviving spouse's coverage as a Dependent of the deceased Member

A surviving spouse may elect either single coverage or family coverage, at the respective applicable Premiums. An election of family coverage provides coverage only for the surviving spouse and those persons who were Dependent children of the deceased Member at the time of death, except that stepchildren are not eligible for benefits under the surviving spouse coverage.

Except as otherwise expressly provided, an individual covered as a surviving spouse in the Non-Active Classification is considered to be a Member for purposes of the Plan.

## **9. 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. However, some Pension Plans do not allow or limit the number of hours worked while drawing a pension benefit. Members who earn Health and Welfare Credit Hours during Non-Active coverage will receive a credit against their self-payment, up to the amount of the Employer contributions received by the Fund on account of hours worked. The credit for hours worked in a month will not exceed the amount of the self-payment applicable for that benefit month.

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

- a. The Member must notify the Plan Office in advance of the intent to have Credit Hours applied to reinstate Active eligibility, in which case Employer contributions for the Member will cease to be credited against self-payments and will begin to be credited toward initial Active eligibility;
- b. The Member must satisfy the requirements for initial Outside or Inside eligibility while maintaining continuous Non-Active coverage; and
- c. Only Credit Hours earned during Non-Active coverage as provided above will be applied to satisfy initial eligibility requirements.

A Member may move from Non-Active to Active coverage only once, except that a Member with Non-Active coverage by virtue of Total Disability who ceases to be totally disabled is not bound by this limitation.

## **10. Termination of Non-Active Eligibility**

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

- a. In case of non-payment of the monthly contribution or payment received after the grace period, the end of the last month for which timely payment was received.
- b. The date of the Member's death.
- c. The date the Member falsifies any information in connection with a claim for benefits, or commits any action with the intent to defraud the Plan.
- d. The date the Plan terminates.

In addition, a Non-Active Member's eligibility for all or most benefits in the Plan will end on the date when the Member is Eligible for Medicare, as provided in Subsections 1.a. and 3 above.

## **11. Non-Active Eligibility after a Gap in Coverage**

If, for any reason, either Active or Non-Active coverage ends for a Member or Dependent, resulting in a "break" in such individual's coverage under this Plan, such individual may be reinstated to (or begin) Non-Active coverage under this Plan only if all of the following conditions are satisfied:

- a. Such individual 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;
- b. Such individual must satisfy all other eligibility requirements for Non-Active coverage; and
- c. Not more than five years must have elapsed since such individual's coverage under the Active or Non-Active Classification in this Plan ended, except in the following cases:
  - 1) A Member's Dependent who opted out of coverage in this Plan who thereafter maintained continuous health coverage through the Dependent's Employer that did not terminate more than 63 days before the requested date for beginning or resuming Non-Active coverage in this Plan; or
  - 2) 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
- d. Surviving spouse coverage must be continuous, and cannot be reinstated after a termination.

Non-Active coverage under this Subsection 11 will be effective the first day of the month following the month in which the required Premium is paid. A Member or Dependent who begins or resumes Non-Active coverage after a gap in coverage under this Plan will not be eligible for Life or Accidental Death and Dismemberment Insurance benefits.

A Covered Person who terminates Non-Active coverage who terminates coverage for any reason may re-establish Non-Active coverage one time only.

## **J. Dependent Coverage**

Except as otherwise provided in the Plan, eligibility of a Member's dependents is determined by the same rules, regardless whether the Member has Active or Non-Active coverage. Coverage of dependents of Members in the Active Classification is automatic. Dependents of Members in the Non-Active Classification are covered only if the Member has 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 in Subsection I.1.a. above. A Member's dependents are the Member's spouse, and each child of the Member under the age of 26 years, provided that the additional conditions of eligibility of spouses and children set forth below are met. Except for a spouse and child, no relative of a Member, or other person, is eligible as a Dependent regardless of financial support by the Member.

### **1. Initial Dependent Coverage**

For all Eligibility Classes, initial coverage of a Member's Dependents is derivative from the Member's eligibility. Coverage of an existing Dependent will begin when the Member's family coverage begins and the Dependent is enrolled. Coverage of a new Dependent of an existing Member with family coverage is automatic, subject to enrollment of the new Dependent.

## **2. Spousal Eligibility**

### **a. Spouse**

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

An individual ceases to be a Member's spouse upon divorce, annulment of marriage, or death. Eligibility and coverage of a Dependent 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.

### **b. Spousal Coverage of Active Members**

The spouse of a Member in the Active Classification will not be eligible as a Dependent unless the Member and spouse provide information about the employment status of the spouse and access of the spouse to Employer sponsored health care, whenever requested by the Plan.

During any period when an Active Member's spouse is employed and eligible to participate in a qualified Employer-sponsored health plan, the spouse must enroll in the qualified plan offered through the spouse's Employer in order to be eligible for benefits in this Plan as a Dependent. When a spouse has complied with this requirement, the plan of the spouse's Employer will be primary, and this Plan will be secondary for benefits due to the spouse.

#### **1) Qualified Plan; Enrollment Options**

For purposes of the spousal coverage rules, a "qualified" Employer-sponsored health plan is a plan that:

- a) Is insured, or self-insured by the Employer, and subject to regulation by state or federal agencies such as the US Department of Labor or Internal Revenue Service; and
- b) Offers industry recognized standard benefits for Medically Necessary Hospitalization, surgery and outpatient medical treatment and prescription coverage.

In case of a choice, a working spouse is required to enroll in at least single (spouse only) coverage at the standard benefit level of a qualified plan (not high-deductible or limited coverage), as well as prescription drug coverage if offered. A spouse is not required to elect dental or vision benefits, or family coverage.

However, if the Trustees determine that it would be in the interest of this Plan to do so, they may require a working spouse to enroll any Dependent children in the spouse's health plan, provided that this Plan pays the Premium that the spouse would be otherwise required to pay to do so.

#### **2) Exceptions**

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:

- a) If the spouse is Self-Employed and has no other employees.
- b) If the spouse is not employed full time within the meaning of Section 4980H of the Internal Revenue Code (generally, less than 30 hours per week or on average less than 130 hours per month).
- c) If the spouse's Employer would not contribute toward the cost of the spouse's health coverage, and would require the spouse to pay 100% of the cost.
- d) 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 coverage, enrollment will not ordinarily be deemed an extreme hardship.

#### **3) Facilitation of Enrollment**

The Benefit Plans Administrator is authorized to terminate eligibility of a dependent spouse for benefits from this Plan if necessary to enable the spouse to enroll in the plan of the spouse's

Employer, and to reinstate eligibility in this Plan after the spouse has enrolled in the plan of the spouse's Employer.

A working spouse will not lose eligibility in this Plan solely on account of a mandatory waiting period following application for enrollment in the Employer's plan, provided that the spouse's application was made in time to prevent loss of eligibility.

#### **4) Verification of Enrollment**

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

#### **5) Failure to Enroll**

If an Active Member's working spouse fails to enroll in an Employer-sponsored health plan when required, or if the Member or spouse or spouse's Employer fails to provide required information requested by the Plan, the spouse's eligibility for benefits in this Plan will terminate. 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 end of the month in which the required enrollment or information is completed, but not retroactively.

For purposes of the spousal coverage rules, "required information" includes a complete response from a Member and spouse to an information request from the Plan, as well as written verification from the spouse's Employer after request from the Plan.

### **3. Dependent Child Eligibility**

#### **a. Child**

For purposes of eligibility for benefits in this Plan, a Member's "child" is any of the following, provided in each case that the child is a "child" or "dependent" of the Member within the meaning of section 105(b) of the Internal Revenue Code:

- 1) A natural child;
- 2) A child adopted by judicial decree;
- 3) A child legally placed for adoption in the Member's home;
- 4) A child for whom the Plan is required to provide coverage pursuant to a Qualified Medical Child Support Order (QMSCO); or
- 5) The Member's stepchild, as long as the child's natural parent is the Member's spouse. If a Member's 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.

#### **b. Eligible Child**

A Member's child is eligible for Dependent coverage until the last day of the calendar month in which child's 26<sup>th</sup> birthday occurs.

#### **c. Disabled Child**

A Member's child may remain eligible for Dependent coverage on and after the child's 26<sup>th</sup> birthday if, and so long as, the child is totally and permanently disabled and the Member is entitled to and does claim a deduction for the child on the Member's federal income tax return.

A Member's child is not eligible for Dependent coverage after age 26 unless, no later than 31 days after the child's 26<sup>th</sup> birthday, and as often thereafter as requested by the Plan, the Member presents proof that the foregoing conditions existed on that birthday and continuously thereafter.

### **4. Opting out of Dependent Coverage**

Any individual eligible for Dependent coverage may opt out of such coverage by signed written notice to the Trustees, specifying the date on which such coverage will terminate. Any individual who has

voluntarily terminated Dependent coverage may reinstate such coverage by written notice to the Trustees, provided that the individual is eligible for Dependent coverage at the time of reinstatement. The parent of a child under the age of 18 may request to opt out of coverage on behalf of the minor child. A dependent child age 18 or older or a spouse must request to opt out of the Plan individually.

#### **5. Termination of Dependent Eligibility**

Except as provided for a Dependent who has elected COBRA, 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:

- a. The date the Member's eligibility ends, except as follows: (1) Eligibility of Dependents of a Member in the Non-Active Classification will not terminate solely because the Member becomes Entitled to Medicare, if and so long as the Member is enrolled in the UHC Medicare Advantage Program. (2) In event of death of a Member 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.
- b. The date the individual no longer qualifies as an eligible Dependent under the terms of the Plan.
- c. 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.
- d. The date the Plan terminates.

#### **K. COBRA Continuation Coverage**

The Plan provisions in this Subsection K summarize COBRA rules likely to apply to this Plan and its Covered Persons, but do not describe all provisions of the law. The Plan will be administered in compliance with the requirements of the Internal Revenue Code and ERISA relating to COBRA continuation coverage. The law shall take precedence in any case where the requirements of the law are more favorable to Covered Persons than the Plan.

Every Qualified Beneficiary who would otherwise lose coverage on account of the Qualifying Event is eligible to elect COBRA continuation coverage. 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.

Unlike most other coverage under the Plan, each individual Member and Dependent who is a Qualified Beneficiary is entitled to make an individual COBRA election upon the occurrence of a Qualifying Event. A Qualified Beneficiary who elects COBRA must pay the COBRA Premiums established by the Trustees in order to begin and maintain COBRA continuation coverage.

##### **1. COBRA Qualifying Events**

Any of the following is a Qualifying Event if it would cause a Qualified Beneficiary to lose coverage in the Plan:

- a. A reduction in a Member's hours of employment,
- b. Termination of a Member's employment for reasons other than gross misconduct.
- c. Bankruptcy of a retired Member's former Employer;
- d. Death of a Member;
- e. Divorce or legal separation of a Member and spouse;
- f. A Member becoming Entitled to Medicare; or

g. A child attaining age 26, or otherwise ceasing to qualify as a Member's Dependent.

## **2. Qualified Beneficiary**

A Qualified Beneficiary is a Covered Person, other than a Member or Dependent whose Active coverage is being maintained by Minimum/Difference payments, who was eligible for benefits in the Plan on the day before occurrence of a Qualifying Event with respect to such Covered Person, and whose coverage would end on account of the Qualifying Event. A Member can be a Qualified Beneficiary only with respect to termination or reduction in hours of the Member's employment, bankruptcy of the Member's Employer, or becoming Entitled to Medicare.

In addition, a child born to or placed with a Member for adoption during a period of the Member's COBRA coverage has an independent right to elect to retain COBRA coverage for the balance of the original COBRA period irrespective whether the Member's continuation coverage ends before the end of the maximum period.

## **3. COBRA Benefits**

The benefits provided under COBRA continuation coverage are the same medical, prescription drug, dental and vision benefits to which the electing Qualified Beneficiary would have been entitled during the continuation period if the Qualifying Event had not occurred. An electing Qualified Beneficiary has the same rights to add Dependents or change coverage as Active Members. Incidental Plan benefits (Life and Accidental Death and Dismemberment insurance and Short Term Disability benefits) are not provided under COBRA.

## **4. Required Notices, Election and Payments for COBRA Continuation Coverage**

### **a. Notices the Qualified Beneficiary Must Give to the Plan**

#### **1) Certain Original Qualifying Events**

A Qualified Beneficiary who would lose coverage because of a Member's divorce or legal separation, or because of a Member's child ceasing to qualify as a Dependent, will lose the right to elect COBRA on account of such Qualifying Event unless the Plan receives notice of the Qualifying Event within 60 days after the latest of:

- a. Such event; or
- b. The date coverage would terminate because of that event.

#### **2) Second Qualifying Event**

If a second Qualifying Event described in the preceding Subsection 1 occurs with respect to a Qualified Beneficiary who is covered under COBRA, that Qualified Beneficiary will lose the COBRA rights associated with the second event unless the Plan receives notice of the second Qualifying Event within 60 days after the latest of:

- a. The date of the second qualifying event; or
- b. The date coverage would otherwise terminate.

#### **3) Social Security Disability Determinations**

A Qualified Beneficiary who has elected COBRA, and who thereafter is determined for purposes of Social Security Disability to have been disabled during the first 60 days of COBRA coverage, will lose the right to a disability extension of COBRA coverage unless the Plan receives notice of the determination within 60 days after the date the determination is issued and also within the original period of COBRA coverage.

If a Qualified Beneficiary's disability under Social Security is determined to have ended, the Qualified beneficiary must notify the Plan no later than 30 days after the date the determination is issued.

### **b. Notices the Plan's Must Give to Qualified Beneficiaries**

Within 30 days after the Plan receives notice of the occurrence of a Qualifying Event, the Plan will notify Qualified Beneficiaries of their COBRA rights.

## **5. Election of COBRA Continuation Coverage**

To become entitled to COBRA continuation coverage, a Qualified Beneficiary must notify the Plan of election of COBRA within 60 days after the later of:

- a. The date the Qualified Beneficiary would lose coverage because of the Qualifying Event, or
- b. The date the Qualified Beneficiary receives the Plan's notice of COBRA rights after the Qualifying Event.

A Qualified Beneficiary elects COBRA continuation coverage by returning a completed COBRA election form to the Plan within the 60 day period. A Qualified Beneficiary may not make a COBRA election after expiration of the time specified above.

Unless otherwise specified in an election, a COBRA election made by a Member or Dependent spouse is an election on behalf of all Qualified Beneficiaries.

## **6. Payment for COBRA Coverage**

The monthly Premium for COBRA continuation coverage is set by the Trustees from time to time. The initial payment is due within 45 days after the date the COBRA election is made. The first payment must include payment for all months between the termination of regular coverage and the date of the election. Subsequent payments are due on the first day of each month, and will not be accepted more than 30 days after the due date. COBRA coverage will terminate permanently if any payment is not made within the allowed time periods.

## **7. Coverage during Election Period and Payment Periods**

The Plan will not pay claims after regular coverage ends on account of a Qualifying Event, until a Qualified Beneficiary both elects COBRA and makes a timely initial payment. Similarly, if a Qualified Beneficiary does not make a monthly payment by the due date, benefits will be suspended until the monthly payment is received before the end of the grace period.

## **8. Duration of COBRA Continuation Coverage**

### **a. Termination or Reduction of Hours of Employment**

If the Qualifying Event is termination or reduction in hours of employment, the maximum period of COBRA continuation coverage ends 18 months after the date of the Qualifying Event unless extended for one of the following reasons:

#### **1) Social Security Disability**

If, prior to the end of the 18-month coverage period, any Qualified Beneficiary who elected COBRA is determined by Social Security to have been disabled during the first 60 days of COBRA coverage, the maximum COBRA continuation period is extended for an additional 11 months. The disabled person, and all other qualified beneficiaries who have COBRA coverage by virtue of the same Qualifying Event, may purchase coverage for up to a total of 29 months from the date of the original qualifying event. The Premium for coverage of the disabled person during the 11-month extension is 150% of the normal COBRA Premium.

#### **2) Medicare Entitlement**

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

#### **3) Second Qualifying Event**

If a second Qualifying Event occurs during the 18-month or 29-month coverage period, and timely notice is given to the Plan, the maximum COBRA coverage period will be extended to 36 months from the date of the original Qualifying Event for the Qualified Beneficiaries affected by the second Qualifying Event. The extension is in lieu of a new period of coverage that would otherwise start with the second Qualifying Event.

### **b. Other Qualifying Events**

For all Qualifying Events other than the termination or reduction in hours of employment, the maximum COBRA continuation period is 36 months from the date of the Qualifying Event.

**9. Termination of COBRA Continuation Coverage**

All rights to COBRA continuation coverage permanently end on the earliest of the following occurrences:

- a. The expiration of the applicable maximum COBRA continuation period;
- b. The Qualified Beneficiary's failure to make a payment before the end of the applicable grace period;
- c. The date on which a Qualified Beneficiary who elected COBRA first becomes covered under Medicare or under another group health plan, except to the extent that the other group plan limits coverage of the individual due to the individual's pre-existing condition;
- d. For COBRA coverage that is extended due to disability, the first day of the first month that begins more than 30 days after the date that the disabled Qualified Beneficiary is finally determined by the Social Security Administration to be no longer disabled.

## Section II

### Medical Benefit

#### A. Levels of Medical Benefit

The Plan's Medical Benefit provides benefits for a wide range of health care services and supplies used to diagnose and treat Injury or Sickness, or to maintain wellness. The Medical Benefit does not cover prescription drugs, vision care or dental care, each of which is covered by a separate benefit and Section. However, some of the provisions of this Section II apply by their terms to Plan benefits in addition to the Medical Benefit.

There are two Schedules of medical benefits within the Plan, set forth in Section V. The Schedule applicable to a Covered Person depends on the rate at which a Member's Employer is contractually obligated to contribute to the Plan.

##### 1. Platinum Schedule of Benefits

The Platinum Schedule is the highest level of medical benefits (providing generally 90% medical Coinsurance), and is the default level applicable to all Members and Dependents who are not covered under the Gold Schedule. A Member or Dependent in the Active Classification who is covered under the Platinum Schedule will continue to be covered under the Platinum Schedule after entering the Non-Active Classification, until such individual is Eligible for Medicare.

##### 2. 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. A Member or Dependent in the Active Classification who is covered under the Gold Schedule will continue to be covered under the Gold Schedule after entering the Non-Active Classification, until such individual is Eligible for Medicare.

##### 3. 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 a Non-Network Provider. Covered Persons are free to choose to obtain most medical services and supplies from either an In-Network Provider or a Non-Network Provider. However, certain services and supplies are covered under the Platinum and Gold Schedules only if obtained from an In-Network Provider, as noted in Subsection C.1. below.

If an In-Network Provider is chosen, the Plan's benefits covered under either the Platinum Schedule or the Gold Schedule are higher than if a Non-Network Provider is chosen. In addition, In-Network Providers may not charge more than the amount contractually agreed with the Network Sponsor, and may not require Covered Persons to pay more than the Copay, or the deductible and Coinsurance share, based on that amount.

If a Non-Network Provider is chosen, the Plan's benefits covered under either the Platinum Schedule or the Gold Schedule are lower than for an In-Network Provider, and are subject in any event to the Plan's reasonable and customary limitation. A Non-Network Provider is not limited in the amount it can charge a Covered Person after receiving the Plan's benefits.

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

- a. **General Medical Networks:** Coventry PPO/ASO and Coventry National Networks are the Plan's General Medical Networks. In-Network benefits apply to all Providers in these Networks, except for organ transplants, and treatment covered as mental health and substance abuse (including the Member Assistance Program).
- b. **Preferred Orthopedic Provider:** Within the Coventry Networks, Signature Health Services is designated by the Plan as a preferred Provider of orthopedic services. In-Network benefits apply to

Signature, and in addition, the Plan will rebate \$150 to a Covered Person who completes the entire course of treatment recommended by Signature (education, surgery and post-operative rehabilitation) for any of the following procedures: total knee replacement, hip replacement, rotator cuff repair or carpal tunnel surgery.

- c. **Transplant Network:** The Plan's Transplant Network is a designated group of Providers within the Coventry Networks. Services and supplies for organ transplants must be obtained in the Transplant Network to be covered.
- d. **Mental Health and Substance Abuse Network:** Mercy Managed Behavioral Health Network is the Plan's Mental Health and Substance Abuse Network. In-Network benefits for treatment of mental health and substance abuse apply only to Providers in this Network. The Member Assistance Program (MAP) is also part of the Mental Health and Substance Abuse Network with certain providers contracted for the MAP services.

The Plan maintains updated information about Networks and In-Network Providers at the Plan Office and on the Plan's website, [www.carpdc.org/BenefitServices](http://www.carpdc.org/BenefitServices).

## **B. Determination of Benefit Amounts**

### **1. Allowable Amount**

Upon receiving a claim, and after confirming that it is an Allowable Claim because the claimant is eligible for benefits, the service or supply is covered by the Plan, and any required pre-authorization was granted, the Plan determines the Allowable Amount of the claim. The Allowable Amount is the maximum benefit that the Plan would pay on a claim if the Coinsurance rate were 100%, and if no deductible or Copay were applicable. For a charge from an In-Network Provider, the Allowable Amount is the uniform charge the Provider has agreed to accept as a Member of the Network. For a charge from a Non-Network Provider, the Allowable Amount is the lesser of the amount charged, or the reasonable and customary amount. In all cases, the Allowable Amount is reduced as necessary to conform to any other specific limitations set forth in the Plan.

### **2. Reasonable and Customary Limit**

For coverage under all Benefit Schedules, the reasonable and customary amount for services and supplies covered by Medicare is equal to 100% of the Medicare approved amount. For services supplies not covered by Medicare, the Trustees have discretion to determine the method by which the reasonable and customary amount will be established and may rely upon data furnished from sources deemed appropriate by the Trustees. In case of a charge from a Non-Network Provider, no Plan benefit will be paid based on an Allowable Amount in excess of the reasonable and customary amount.

### **3. Deductibles**

The Plan's deductible is an aggregate annual amount that must be paid by a Covered Person toward Allowable Claims incurred in a calendar year before any Plan benefits become payable for claims incurred in that year. The Individual Deductible is the deductible amount that must be paid on behalf of any individual Covered Person before Plan benefits will be paid to or for that person, unless and until the Family Deductible is satisfied. The Family Deductible is the deductible amount that, once paid for any combination of a Member and the Member's Dependents, satisfies the Individual Deductible for the Member and all of the Member's Dependents for claims incurred during the remainder of the calendar year. The deductible does not apply to a benefit for which a Copayment is required.

### **4. Copayments**

A Copayment is a fixed dollar amount that must be paid by a Covered Person towards an Allowable Claim for a particular service or supply, as set forth in the applicable Schedule of Benefits. Copayments for a service or supply are in lieu of any Coinsurance for that service or supply, and are payable whether or not the Covered Person's deductible has been met. Copayments are no longer required if an Out-of-Pocket Maximum applicable to the claim has been satisfied.

## **5. Coinsurance**

After any applicable deductible is satisfied, Coinsurance is the percentage of the remaining Allowable Amount that will be paid by the Plan for a particular service or supply, as set forth in the applicable Schedule of Benefits. The balance of the claim is payable by the Covered Person who incurred the claim. If an Out-of-Pocket Maximum applicable to the claim has been satisfied, the Coinsurance rate becomes 100%.

## **6. Out-of-Pocket Maximum**

The individual Out-of-Pocket Maximum for medical benefits is an annual amount that, when satisfied, relieves a Covered Person from further deductibles and Copayments, and changes the Coinsurance rate to 100%, for all further In-Network Allowable Claims incurred in the same year. The individual Out-of-Pocket Maximum is satisfied when the sum of all deductibles, Copayments, and charges in excess of the Plan's Coinsurance share that are paid by a Covered Person on account of In-Network Allowable Claims incurred in a calendar year equals the Individual Out-of-Pocket Maximum amount stated in the applicable Schedule of Benefits. When the combined amount of such payments made in a calendar year for any combination of a 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 claims incurred during the remainder of the same calendar year. Amounts paid by a Covered Person on account of a Non-Network claim do not count toward satisfying the Out-of-Pocket Maximum. Regardless of satisfying the Out-of-Pocket Maximums, a Covered Person is responsible for the following:

- a. Charges for services and supplies not covered by the Plan;
- b. Charges from a Non-Network Provider in excess of the Plan's Allowable Amount;
- c. Charges from a Non-Network Provider for which no Plan benefits are paid because of failure to obtain required Prior Authorizations; and
- d. Charges in excess of Plan benefits for services and supplies within the Prescription Drug Benefit, the Dental Benefit or the Vision Benefit.

## **7. Specific Plan Limits**

The Plan limits the number of days, visits or other quantities of certain specific kinds of services and supplies for which benefits will be paid. Quantities in excess of these limits are not services and supplies covered by the Plan. The Plan also limits the dollar amount of benefits that will be paid for certain specific covered services and supplies. Irrespective of all other factors, the benefits actually paid by the Plan for such services and supplies will not exceed the limit amount. These specific limitations are set forth in the Schedules of Benefits and Subsection C below.

## **8. Benefit Payable**

The benefit payable by the Plan for an Allowable Claim is the Allowable Amount, less the Copayment if any Copayment is required, less the unsatisfied amount of any applicable deductible, multiplied by the applicable Coinsurance percentage, subject to any specific limitations. If an applicable Out-of-Pocket Maximum is satisfied, the benefit payable is the Allowable Amount, subject to any specific limitations.

For covered services and supplies listed and designated as Preventive services and supplies in Subsection C.2 below, the benefit payable by the Plan is the Allowable Amount.

## **C. Covered Services and Supplies**

No benefits are provided for services and supplies that are not covered by the Plan. Except as otherwise specifically provided, the Plan covers only those services and supplies that are

- listed in Subsections C.1 and C.2 as covered,
- Medically Necessary, unless otherwise stated in Subsections C.1 and C.2;
- performed or ordered and supervised by a Physician, or other medical professional if noted; and
- not excluded under the general exclusions and limitations set forth in Subsection C.3 below.

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

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

Inclusion of a service or supply in this Table C.1 means that the service or supply is eligible for coverage under the Platinum and Gold Schedules of Benefits, with stated limitations, but does not guarantee whether, or to what extent, benefits are payable.

<b>TABLE C.1 NON-PREVENTIVE SERVICES AND SUPPLIES</b>		
<b>SERVICE OR SUPPLY</b>	<b>EXTENT OF COVERAGE</b>	<b>AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS</b>
Abortion (Elective)	Elective Abortion is covered only if the attending Physician certifies that carrying the fetus to term would directly endanger the life of the mother, or that the condition of the fetus is likely to result in death of the fetus during Pregnancy or within a few hours of delivery.	Prior Authorization required.  <b>Exclusions:</b> Listed service or supply if Prior Authorization was not obtained.  All elective Abortions are excluded except as stated.
Allergy Care	Allergy testing, diagnosis, treatment, allergy serum, administration of injections, and prescribed medications.	<b>Exclusions:</b> Services and supplies not administered by a Physician, such as, but not limited to, air filters, air purifiers, or air ventilation system cleaning.
Ambulance Service	Emergency ground medical transport services are covered only if all of the following criteria are met:  <ol style="list-style-type: none"> <li>1. The medical transport services complies with all local, state and federal laws and has all appropriate, valid licenses and permits; and</li> <li>2. The ambulance has the necessary patient care equipment and supplies; and</li> <li>3. The patient’s condition is such that any other form of transportation is medically contraindicated; and</li> <li>4. 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.</li> </ol> <p>Emergency air or water medical transport service is an exceptional circumstance, covered only if all of the above-stated criteria pertaining to ground transportation are met as well as any one or more of the following:</p> <ol style="list-style-type: none"> <li>1. The patient’s medical condition is such that the time needed to transport the patient by land poses a significant threat to the patient’s health or life and requires immediate and rapid ambulance transport that could not be</li> </ol>	Prior Authorization is required for non-emergent transportation from one Hospital or medical facility to another.  <b>Limitations:</b> Emergency air or water transport is covered only for the lowest cost aircraft or vessel that is available and appropriate for the patient’s medical condition.  <b>Exclusions:</b> All ambulance transportation services are excluded if the required criteria are not met.

	<p>provided by land ambulance; or</p> <p>2. The point of pickup is inaccessible to a land vehicle; or</p> <p>3. Great distances, limited time frames, or other obstacles to land transport would prevent getting the patient to the nearest Hospital with appropriate facilities for treatment.</p>	
Anesthesia	Anesthesia administered by a Physician or qualified allied health professional.	<p><b>Exclusions:</b></p> <p>Anesthesia in conjunction with non-covered medical or surgical procedures.</p>
Assistant Surgeon	Services of an assistant surgeon who actively assists the primary surgeon, but only when the type of surgery requires assistance according to generally accepted medical practice.	<p><b>Limitations:</b></p> <p>The Allowable Amount for services of an Assistant Surgeon reduced according to industry standards from the Allowable Amount for the services of the primary surgeon.</p>
Blood and Blood Products	Administration, storage and processing of blood and blood products in connection with covered services and supplies.	<p><b>Exclusions:</b></p> <p>Harvesting and storage of a patient's own blood, except for potential use in a covered, scheduled surgical procedure.</p> <p>Fetal cord blood harvesting and storage.</p>
Brachytherapy	Brachytherapy treatment is covered.	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Breast Reconstruction	Following a Medically Necessary mastectomy, breast reconstructive surgery and prosthesis are covered regardless whether Medically Necessary, including nipple reconstruction, augmentation or reduction of the affected breast, augmentation or reduction of the opposite breast to restore symmetry, internal or external prosthesis, and lymphedema..	<p><b>Exclusions:</b></p> <p>Reduction or augmentation mammoplasties that are not Medically Necessary and are unrelated to a Medically Necessary mastectomy.</p>
Cardiac Diagnostic Testing	Cardiac diagnostic testing is covered when considered Medically Necessary when used to determine diagnosis. Examples of cardiac testing include angiography, cardiac catheterizations, radio frequency ablations, cardiac stress imaging and stress echocardiograms.	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Cardiac Rehabilitation Therapy	Rehabilitation following cardiac surgery or disease to restore health as much as possible through exercise and education.	<p><b>Limitations:</b></p> <p>36 visits per calendar year</p>
Chemotherapy and	Standard chemotherapy and radiation therapy, including Intensity Modulated Radiation Therapy	Prior Authorization required.

Radiation Therapy	(IMRT), Stereotactic Radiation Therapy, Proton Beam Therapy, and dose-intensive chemotherapy.	<b>Exclusions:</b> Listed service or supply if Prior Authorization was not obtained.
Chiropractic Services	Chiropractic therapy within the scope of Provider's license, including initial diagnosis and supplies.	<b>Limitations:</b> Benefits are limited to \$42 per visit and \$1,500 annually. <b>Effective 5/1/2015</b> Benefits are limited to 40 visits per calendar year per patient with no per visit or annual dollar limits.
Clinical Trials	Routine patient care incurred as a result of enrollment in Phase I, II, III or IV clinical trials undertaken for the purposes of the prevention, early detection, or treatment of cancer, if the clinical trial is conducted at an academic or NCI center and is approved or Funded by one the following entities:  <ol style="list-style-type: none"> <li>1. National Institute of Health (NIH);</li> <li>2. An NIH cooperative group or center;</li> <li>3. The FDA in the form of an investigational new drug application;</li> <li>4. The federal Departments of Veterans' Affairs or Defense;</li> <li>5. A qualified research entity that meets the criteria for NIH Center support grant eligibility;</li> <li>6. An institutional review board that has an appropriate assurance approved by the Department of Health and Human Services.</li> </ol>	Prior Authorization required. <b>Exclusions:</b> Patient care for any clinical trial that does not meet the stated criteria; any non-health care services required in conjunction with the clinical trial (such as transportation, lodging, Custodial Care); services and supplies provided to enrollees in the clinical trial without charge; services required to conduct, manage and administer the clinical trial or to collect and analyze data; and supplies and services that would not be covered for reasons other than being Experimental or Investigative.  Listed service or supply if required Prior Authorization was not obtained.
Cosmetic, Plastic and Related Reconstructive Surgery	Surgical correction of congenital birth defects or the effects of disease or Injury, provided that the surgery repairs defects resulting from an accident within one year of the accident or as soon thereafter as medically appropriate; replaces diseased tissue surgically removed, within one year of the surgery or as soon thereafter as medically appropriate; treats a birth defect in a child as soon as medically appropriate; or is covered under the Plan's criteria for breast reconstruction following a covered mastectomy.  See also coverage of Breast Reconstruction.	Prior Authorization required. <b>Exclusions:</b> Services or supplies that are not obtained as soon as medically appropriate.  Except as expressly listed, cosmetic or reconstructive procedures and any related services or supplies which alter appearance but do not restore or improve impaired physical function.  Listed service or supply if Prior Authorization was not obtained.
Dental Services	Administration of general anesthesia in any facility, and Hospital charges, for dental care provided to the following Covered Persons only when authorized in	Prior Authorization required. <b>Exclusions:</b> Except as provided in this list, the

	<p>advance by the Plan:</p> <ol style="list-style-type: none"> <li>1. A child under the age of five;</li> <li>2. A person who is severely disabled; or</li> <li>3. A person who has a medical or behavioral condition which requires Hospitalization or general anesthesia when dental care is provided.</li> </ol> <p>See also coverage of Oral Surgery.</p>	<p>care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery for impacted teeth, surgery involving structures directly supporting the teeth, dental implants or orthodontia, oral surgical procedures (including services for overbite or under bite, whether the services are considered to be medical or dental in nature, are not covered in the Medical Benefit. In addition, dental x-rays, supplies, and appliances (including occlusal splints and orthodontia), removal of dentiginous cysts, mandibular tori and odontoid cysts, and removal of teeth due to an Injury, prior to radiation or for radionecrosis, are also not covered in the Medical Benefit, but may be covered in the Plan's Dental Benefit.</p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Dermatological Care	<p>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.</p>	<p><b>Exclusions:</b></p> <p>All cosmetic procedures except as stated.</p>
Diagnostic and Treatment Services	<p>The following services rendered by a Physician, whether in or out of the Physician's office:</p> <ul style="list-style-type: none"> <li>• Diagnosis and treatment of covered illness or Injury.</li> <li>• Administration of Injectable medication normally rendered in a Physician's office.</li> <li>• Consultations with specialists.</li> <li>• Performance of laboratory tests.</li> </ul> <p>See also coverage of Laboratory Services.</p>	
Dialysis	<p>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.</p>	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Diabetic Supplies	<p>Plan approved glucose meters, insulin pumps and cartridges, and self-management training used in connection with the treatment of diabetes.</p>	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Disposable insulin syringes, glucose strips, and lancets are not covered in the Medical Benefit, but may be covered under the Prescription Drug</p>

		Benefit. Listed service or supply if Prior Authorization was not obtained.
Durable Medical Equipment (DME)	<p>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:</p> <ol style="list-style-type: none"> <li>1) It can withstand repeated use;</li> <li>2) It is primarily and customarily used to serve a medical purpose;</li> <li>3) It is generally not useful to a person in the absence of illness or Injury;</li> <li>4) It is appropriate for use in the home; and</li> <li>5) It does not exceed the minimum specifications that are Medically Necessary.</li> </ol> <p>Coverage is for the rental if not expected to exceed the purchase price, or for purchase if rental is expected to exceed the price, of Durable Medical Equipment only when authorized in advance by the Plan, and ordered by or provided by or under the direction of a Physician for use outside a Hospital or Skilled Nursing Facility.</p> <p>Covered equipment can include, but is not limited to the following: wheelchairs; standard Hospital-type 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.</p>	<p>Prior Authorization required.</p> <p><b>Limitations:</b></p> <p>Upgrades to equipment are not covered unless Medically Necessary due to change in the patient's condition.</p> <p>Replacement of purchased equipment that has become non-functional and non-repairable due to normal, routine wear and tear is covered only after 5 years from date of purchase, or the expected life if less, during which time the Covered Person has been continuously eligible for Plan benefits.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained.</p> <p>Equipment that does not satisfy all stated criteria, or is superior to other alternatives primarily because of comfort or convenience, regardless whether prescribed by a Physician. Exercise equipment, air purifiers, central or unit air conditioners, humidifiers and dehumidifiers, allergenic pillows or mattresses and water beds are examples of excluded equipment.</p>
Durable Medical Equipment Supplies	<p>Non-disposable supplies needed for use of covered Durable Medical Equipment, except over the counter supplies.</p> <p>Supplies related to a TENS unit are only covered with the initial purchase of the TENS unit.</p>	<p><b>Exclusions:</b></p> <p>Over the counter supplies and all disposable supplies.</p>
Emergency Services	<p>Services and supplies furnished or required to screen and stabilize an Emergency medical condition, when provided on an outpatient basis at either a Hospital or an Alternate Facility.</p>	<p><b>Exclusions:</b></p> <p>No benefits are payable for non-Emergency services received in the Emergency room.</p>
Enteral Tube Feeding	<p>Enteral or parenteral nutrition.</p>	<p>Prior Authorization required</p> <p><b>Exclusions:</b></p> <p>Nutritional support that is taken orally.</p>
Eyeglasses and Corrective Lenses	<p>The first pair of eyeglasses or corrective lenses following cataract surgery is covered by the Plan.</p> <p>Additional coverage may be available under the Vision</p>	<p>Exclusions:</p> <p>No other coverage for eyeglasses and corrective lenses under medical is</p>

	Benefit.	allowed.
Genetic Testing and Counseling	Genetic testing, counseling and studies for diagnosis or treatment of genetic abnormalities.	Prior Authorization required. <b>Exclusions:</b> Listed service or supply if Prior Authorization was not obtained.
Home Health Care Services	Home health care services delivered through a Home Health Agency only when all of the following requirements are met:  <ol style="list-style-type: none"> <li>1) Services are a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist;</li> <li>2) The services are a substitute or an alternative to Hospitalization;</li> <li>3) The services are Part-Time and intermittent;</li> <li>4) A treatment plan has been established and periodically reviewed by the ordering Physician;</li> <li>5) The services were approved in the Plan's Prior Authorization procedures;</li> <li>6) The agency rendering services is Medicare certified and licensed by the State of location; and</li> </ol> <p>The patient is homebound or confined in a custodial setting.</p>	Prior Authorization required. <b>Limitations:</b> Home Health visits are limited to 100 visits per calendar year. A visit is defined as 4 or less hours. <b>Exclusions:</b> Listed service or supply if Prior Authorization was not obtained
Hospice	Hospice care rendered for treatment of a Covered Person through a Hospice Agency or Hospice Care Program with a prognosis of six (6) months or less to live. Includes supportive care involving the evaluation of the emotional, social and environmental circumstance related to or resulting from the illness, and guidance and assistance during the illness for the purpose of preparing the patient and the patient's family for imminent death.	
Hyperbaric Oxygen Therapy (HBOT)	Hyperbaric Oxygen Therapy is covered.	Prior Authorization required. <b>Exclusions:</b> Listed service or supply if Prior Authorization was not obtained.
Implants and Related Health Services	Implant devices and related implantation services including pacemakers, joint replacements, AEDs, implantable TENS units, spinal braces, penile implants (unless prescribed to treat impotence which is psychological in origin), and implants for the delivery of prescription medication.  See coverage of Preventive implants for contraception in Subsection C.2 below.	Prior Authorization required, except contraceptive implants covered as Preventive. <b>Limitations:</b> Penile implants are limited to one (1) per Lifetime. <b>Exclusions:</b> Listed service or supply if Prior

		<p>Authorization was not obtained</p> <p>Replacement of covered implants is not covered, except when Medically Necessary due to a change in the patient's condition.</p>
Impotence	Treatment for male organic impotence.	<p><b>Limitations:</b></p> <p>Treatment for male psychogenic impotence is covered only under the Mental Health benefit.</p>
Infertility	Only diagnostic studies up to the point of an infertility diagnosis are covered.	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Treatment of infertility.</p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Injectable medications	Injectable medications when FDA-approved for the patient's disease or condition, and administered by an appropriately licensed medical professional.	<p><b>Exclusions:</b></p> <p>Self-Injectable medications are excluded from the Medical Benefit, and may be available under the Prescription Drug Benefit.</p>
Inpatient Hospital Care	Semi-private Accommodations, Intensive Care Unit, or Coronary Care Unit, as appropriate; general nursing care; use of operating room, surgical and anesthesia services and supplies; blood and blood products; ordinary casts, splints and dressings; all drugs and oxygen used in 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.	<p>Prior Authorization required, except maternity admission for delivery and postpartum care first 48 hours after vaginal delivery or first 96 hours after cesarean section.</p> <p><b>Limitations:</b></p> <p>Medical Necessity is subject to continuous review.</p> <p>Coverage is for the lowest level of care that is Medically Necessary, and will cease if inpatient care is no longer Medically Necessary.</p> <p><b>Exclusions:</b></p> <p>Personal comfort and convenience items or services during inpatient stay, such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.</p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Laboratory Services	Laboratory services within the standard of care for the particular diagnosis.	<p>Prior Authorization required for genetic testing.</p> <p><b>Limitations:</b></p> <p>Coverage is limited to services that are less costly and likely to produce results equivalent to the prescribed</p>

		<p>services, when clinically appropriate.</p> <p><b>Exclusions:</b></p> <p>Laboratory services that are in excess of the standard of care, and laboratory services without Prior Authorization.</p>
Mastectomy	<p>Mastectomies are covered.</p> <p>See also coverage of Breast Reconstruction.</p>	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Maternity Services	<p>Maternity-related medical, Hospital and other covered services and supplies for the mother and her newborn child, including up to forty-eight (48) hours of inpatient post-natal maternity care for vaginal delivery and ninety-six (96) hours of inpatient post-natal maternity care for cesarean delivery. If there is a shorter length of stay, post-discharge care is covered as follows: Up to two (2) visits, at least one (1) of which may be in the home, in accordance with maternal and neonatal physical assessments, by a Physician or a registered professional nurse with experience in maternal and child health nursing .</p> <p>Services of certified and licensed Mid-Wives are covered in the states in which they practice.</p>	<p><b>Limitations:</b></p> <p>Notification of the Plan by the patient, and Prior Authorization, required for an inpatient stay beyond 48 hours after vaginal delivery or 96 hours after a caesarian section delivery.</p> <p><b>Exclusions:</b></p> <p>Home delivery is excluded from the Plan.</p>
Medical Complications	<p>Complications arising from a covered surgical procedure.</p>	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Complications resulting from failure to follow the prescribed course of treatment, and complications arising from a service or supply not covered by the Plan.</p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Medical Services in a Physician's Office	<p>See coverage of Office Visits.</p>	
Member Assistance Program (MAP)	<p>Regardless whether Medically Necessary, confidential counseling services in the following areas are covered only if offered and obtained in the Plan's Member Assistance Program</p> <ul style="list-style-type: none"> <li>• Stress Management</li> <li>• Legal problems</li> <li>• Positive drug/alcohol test</li> <li>• Marital and family counseling</li> <li>• Parenting</li> <li>• Anxiety, depression and grief</li> </ul>	<p><b>Limitations:</b></p> <p>6 visits per episode.</p> <p><b>Exclusion:</b></p> <p>MAP services are available only through the Mercy Member Assistance Program which is a part of the Mercy Managed Behavioral Health Network.</p> <p>To obtain services through the MAP call 314-729-4600 or toll-free at 800-413-8008.</p>
Mental Health and	<p>Services and supplies for diagnosis and treatment of</p>	<p>Prior Authorization required for all</p>

Substance Abuse Services (MHSA)	mental health and substance abuse conditions are covered, subject to all limitations and restrictions of the Plan applicable to particular services and supplies. In-Network Providers for these services and supplies are limited to those Providers in the Plan’s Mental Health and Substance Abuse Network.	facility services.
Newborn Inpatient Care After Discharge of Mother	Services and supplies otherwise covered are also covered, as applicable, for care of neonates. In addition, services and supplies for diagnosis and treatment of conditions unique to newborns are covered, subject to all limitations and restrictions of the Plan, including congenital defects, birth abnormalities, or prematurity, and transportation of the newborn to and from the nearest facility that is appropriately staffed and equipped to treat the newborn’s condition.	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Transportation of newborn for health care unnecessary for appropriately staffed and equipped facility.</p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Oral Surgery and Diseases of the Mouth	<p>Services and supplies required for treatment of an Injury to the jaw as a result of an accident, provided treatment is received as soon as medically appropriate.</p> <p>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.</p> <p>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.</p> <p>Diseases of the mouth, except dental disease or disease of dental origin.</p> <p>Diagnosis and surgical treatment for temporomandibular joint disorder (TMJ) and craniomandibular joint disorder.</p> <p>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.</p> <p>See also coverage of Dental Services.</p>	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Any listed service or supply for which Prior Authorization was not obtained.</p> <p>Dental diseases, and services and supplies covered in the Plan’s Dental Benefit.</p> <p>Orthodontic treatment of TMJ, and orthodontic appliances for such treatment.</p> <p>Services and supplies required for treatment of an Injury to teeth as a result of an accident are excluded but may be covered under the Plan’s Dental Benefit.</p>
Orthotics for Feet	Custom made foot orthotics. Replacement orthotics are covered provided the replacement is prescribed by a Physician and Medically Necessary due to a change in the patient’s physical condition.	<p><b>Limitations:</b></p> <p>New and replacement orthotics are limited to \$1,000 per Covered Person per calendar year.</p> <p><b>Exclusions:</b></p> <p>Over the counter orthotics or other inserts not custom made for the patient.</p>
Outpatient	Prescheduled outpatient diagnostic tests and	Prior Authorization is required for

Diagnostic Tests and Therapeutic Treatments	therapeutic treatments ordered by an attending Physician, performed at a Hospital or Alternate Facility, including but not limited to CT Scans, Pet Scans, Ultrasound, Echo Cardiogram, MRI and MRA, chemotherapy, and radiation therapy.	those diagnostic tests and therapeutic treatments so specified in a list maintained by the Plan, available by calling the Benefit Office and on the Plan's website at <a href="http://www.carpdc.coventryhealthcare.com">www.carpdc.coventryhealthcare.com</a> .  <b>Exclusions:</b> Listed service or supply if required Prior Authorization was not obtained.
Outpatient Surgery	Services and supplies for prescheduled outpatient surgery performed at a Hospital or Alternate Facility under the direction of an attending Physician.  Tubal ligation, tonsillectomy, adenoidectomy, myringotomy tubes and breast biopsy do not require Prior Authorization.	Prior Authorization is required for those outpatient surgical procedures so specified in a list maintained by the Plan, available by calling the Benefit Office and on the Plan's website at <a href="http://www.carpdc.coventryhealthcare.com">www.carpdc.coventryhealthcare.com</a> .  <b>Exclusions:</b> Listed service or supply if required Prior Authorization was not obtained.  Experimental or Investigational surgical procedures or devices used as part of the surgery are not covered.
Pain Management	Pain management services and supplies, pain management injections (including epidural, trigger point and facet injections) are covered.	Prior Authorization required.  <b>Exclusions:</b> Listed service or supply for which Prior Authorization was not obtained.
Phenylketonuria (PKU) or other Amino and Organic Acid Inherited Disease Formula and Food	Formula and low protein modified food products used for PKU or any other amino and organic acid inherited disease when prescribed by a Physician, conditioned on Prior Authorization.	Prior Authorization required.  <b>Limitations:</b> Coverage is limited to children under the age of six (6).  <b>Exclusions:</b> Listed service or supply for which Prior Authorization was not obtained.
Podiatry	Services of a podiatrist are covered, including without limitation, foot care obtained in connection with a diagnosis of diabetes such as clipping nails or treating corns, calluses.	<b>Exclusions:</b> Lithotripsy for treatment of plantar fasciitis is excluded.  Over the counter inserts are excluded.
Office Visits	Services and supplies are covered if appropriately provided during an office visits to a Physician, including but not limited to <ul style="list-style-type: none"> <li>• Diagnosis and treatment of illness or Injury.</li> <li>• Injectable medication that requires supervision from a health care professional and is normally rendered in a Physician's</li> </ul>	<b>Exclusions:</b> Self-injectible medications.

	<p>office.</p> <ul style="list-style-type: none"> <li>• Consultations with Specialists.</li> </ul>	
Preventive Services	See Subsection C.2 below.	
Pregnancy	<p>Diagnosis and treatment of Pregnancy is covered on the same basis as any illness or Injury.</p> <p>See also Covered Preventive Care for Women Including Pregnant Women in Subsection C.2 below.</p>	<p>Prior Authorization required for a Hospital stay longer than 48 hours after vaginal delivery or 96 hours after cesarean section.</p> <p>Notification of Pregnancy in the 1<sup>st</sup> Trimester is recommended.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if required Prior Authorization was not obtained</p>
Prosthetic Devices and Braces	<p>Prescribed prosthetics for initial replacement of a lost natural body part are covered, including, but not limited to, purchase of artificial limbs, breasts, and eyes, limited to the basic functional device which will restore the lost body function or part. For placements requiring a temporary, followed by a permanent, placement only one (1) device will be covered. Replacement of a prosthesis furnished by the Plan, except breast prosthesis, will be covered only if it becomes non-functional and non-repairable due to normal wear and tear, or is Medically Necessary due to a physical change on the part of the patient. For breast prosthetics, replacement will be covered if determined necessary by the patient's Physician.</p> <p>Splints and braces, other than dental braces, are covered, including necessary adjustments to shoes to accommodate leg braces.</p> <p>See also coverage of Orthotics for Feet.</p>	<p>Prior Authorization required for prosthetic devices over \$10,000, and for refitting or replacements.</p> <p><b>Exclusions:</b></p> <p>Over the counter braces, splints and prostheses.</p> <p>Listed service or supply if required Prior Authorization was not obtained</p>
Pulmonary Rehabilitation Therapy	Pulmonary rehabilitation therapy is covered.	<p><b>Limitations:</b></p> <p>Limited to 12 visits per calendar year.</p>
Radiology	Radiology services and supplies are covered.	<p>Prior Authorization is required for those radiology services and supplies so specified in a list maintained by the Plan, available by calling the Benefit Office and on the Plan's website at <a href="http://www.carpdc.coventryhealthcare.com">www.carpdc.coventryhealthcare.com</a>.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if required Prior Authorization was not obtained.</p>
Reconstructive Surgery	See coverage of Breast Reconstruction and Cosmetic, Plastic and Reconstructive Surgery.	
Rehabilitation Services and Supplies Visits	Physical Therapy, Occupational Therapy, and Speech Therapy prescribed by attending Physician, and provided in an outpatient setting by a physical therapist or occupational therapist, and for Speech Therapy a speech pathologist, audiologist or	<p><b>Limitations:</b></p> <p>60 visits per year, all listed types combined</p>

	<p>speech/language pathologist, within the scope of their respective licenses.</p> <p>See coverage of Home Health Care Services for therapy administered in home or in a custodial setting.</p>	<p><b>Exclusions:</b></p> <p>Rehabilitative services provided for long-term, chronic medical conditions.</p> <p>Rehabilitative services whose primary goal or effect is to maintain patient's current level of function, as opposed to improving functional status.</p> <p>Educational or vocational therapy designed to retrain patient for employment.</p> <p>Rehabilitative services whose purpose is to improve a developmental or learning disability or delay.</p> <p>Alternative rehabilitation services such as, massage therapy.</p> <p>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.</p>
Sclerotherapy	Treatment of varicose veins is covered.	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Sleep Studies	Sleep studies to diagnose obstructive sleep apnea are covered.	<p>Prior Authorization required.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained.</p>
Skilled Nursing Facility (SNF) Services	Confinement in SNF, together with medical services and supplies provided in the SNF, are covered only for care and treatment that cannot be safely or effectively provided in an outpatient setting, as determined by the Plan.	<p>Prior Authorization required.</p> <p><b>Limitations:</b></p> <p>SNF confinement for maximum of 100 days per calendar year.</p> <p>Accommodations limited to semi-private.</p> <p><b>Exclusions:</b></p> <p>Listed service or supply if Prior Authorization was not obtained</p>
Sterilization	<p>Vasectomy is a covered procedure in an office setting.</p> <p>Tubal ligation is covered as a Preventive benefit; see Table C.2</p>	<p><b>Exclusions:</b></p> <p>Reversal of sterilization is not covered.</p>
Termination of Pregnancy	See coverage of Abortion.	
TMJ	See coverage of Oral Surgery.	

Transplants (Organ)	Services and supplies for organ transplants are covered only if obtained in the Plan's Transplant Network, and are conditioned on Prior Authorization.	Prior Authorization required. <b>Exclusions:</b> Any transplant service by a Provider outside of the Transplant Network. Listed service or supply if Prior Authorization was not obtained.
Transplant Travel Benefits	<p>Travel Benefits are available only for a transplant Member and their spouse or significant other and the living donor for lodging, meal charges and transportation to and from a facility for evaluation and transplant services if these conditions are met:</p> <ol style="list-style-type: none"> <li>1. The Carpenters' Benefit Plan is the primary benefit payer; and</li> <li>2. An approved facility within the transplant Network is used; and</li> <li>3. The patient and living donor live greater than 50 miles one way from the approved facility; and</li> <li>4. Transplant travel pertains to travel within the United States.</li> </ol> <p>Air travel is recommended when Member and living donor live greater than 150 miles one way from the approved facility.</p> <p>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.</p> <p>Reasonable expenses as determined by the Trustees are covered for parking, taxi and shuttle buses.</p>	<p>Prior Authorization is required.</p> <p><b>Exclusions:</b></p> <p>Total travel benefit per transplant of \$10,000 includes the Member and living donor.</p> <p>Accumulation of benefits begins with the start date of the evaluation appointment with the transplant facility to 12 months following the discharge date from the transplant facility post-transplant.</p> <p>Meal reimbursement limited to \$25 per day per person.</p> <p>Lodging is limited to \$90 per day for Member &amp; \$90 per day for the living donor. Maximum total lodging per day is \$180 if two people accompany a child transplant Member.</p> <p>Air travel is limited to the transplant Member, plus one other person or for both parents if for child transplant Member.</p>
Urgent Care Services	Urgent care services provided at an Alternate Facility such as an urgent care center are covered.	

## 2. Listed Preventive Services and Supplies

The Preventive services and supplies listed in the following Table C.2 are eligible for coverage under the Platinum and Gold Benefit Schedules regardless of Medical Necessity unless otherwise stated. Except as noted, benefits for Preventive services and supplies listed in Table C.2, if obtained from an In- Network Provider, are payable without cost sharing; i.e., payable at a 100% Coinsurance rate without any deductible or Copayment. A service or supply listed in Table C.2 and obtained from a Non-Network Provider is subject to the reasonable and customary limitation, and deductibles, Copays and Coinsurance in accordance with the applicable Benefit Schedule. Inclusion of a service or supply in Table C.2, alone, does not guarantee that benefits are payable.

The Plan's Preventive services and supplies listed in Table C.2 are intended to conform to all of the following:

- a. recommendations of the United States Preventive Services Task Force with rating of A or B;
- b. immunizations with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control; and

- c. for women, infants, children and adolescents, guidelines supported by the Health Resources and Services Administration, all of which are referred to herein jointly as the “Preventive Recommendations.”.

The Preventive Recommendations are incorporated herein by reference, and the provisions of this Subsection C.2 shall be interpreted accordingly. Table C.2 shall be automatically amended as necessary from time to time to conform to future changes in the Preventive Recommendations.

TABLE C.2 PREVENTIVE SERVICES AND SUPPLIES		
SERVICE OR SUPPLY	EXTENT OF COVERAGE	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
Covered Preventive Services for All Adults	<p><b>The services and supplies listed in this box, delivered to a Covered Person by a Physician as part of an annual Preventive exam, are covered under the Platinum and Gold Benefit Schedules to the extent and under the conditions specified in the Preventive Recommendations:</b></p> <p>Abdominal Aortic Aneurysm - Once-in-Lifetime screening for men of specified ages who have ever smoked</p> <p>Alcohol Misuse - Screening and Counseling</p> <p>Aspirin (OTC) – Covered only under the Prescription Drug Benefit</p> <p>Blood Pressure Screening</p> <p>Cholesterol Screening - Screening for adults of specified ages or at higher risk</p> <p>Colorectal Cancer Screening - Screening for adults over 50 years of age</p> <p>Depression Screening</p> <p>Type 2 Diabetes Screening - Screening for adults with high blood pressure.</p> <p>Diet counseling – for adults at higher risk for chronic disease.</p> <p>HIV Screening – for all adults at higher risk.</p> <p>Immunization – in specified doses, for specified ages and populations:</p> <ul style="list-style-type: none"> <li>• Hepatitis A –if a risk factor is present</li> <li>• Hepatitis B –if a risk factor is present</li> <li>• Herpes Zoster – for specified ages</li> <li>• Human Papillomavirus</li> <li>• Influenza (flu shot)</li> <li>• Measles, Mumps, Rubella – for adults born in or after 1957 who lack documentation of 1 or more doses of MMR</li> <li>• Meningococcal – for first year college students and patients with risk factors</li> </ul>	<p><b>Limitations:</b></p> <p>A listed service or supply is covered once each calendar year, unless otherwise stated.</p>

	<ul style="list-style-type: none"> <li>• Pneumococcal –over age 65, or if a risk factor is present</li> <li>• Tetanus, Diphtheria, Pertussis – for adults with unknown or incomplete history of prior vaccination</li> <li>• Varicella – for adults without evidence of immunity to varicella</li> </ul> <p>Lung cancer screening for certain adults age 55-80 with history of risk factors</p> <p>Obesity Screening and counseling</p> <p>Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk.</p> <p>Tobacco Use – Screening for all adults, and cessation interventions for tobacco users. Cessation coverage is limited to the Plan’s approved program.</p> <p>Syphilis – Screening for all adults at higher risk.</p>	
<p><b>Additional Covered Preventive Services for Women, Including Pregnant Women</b></p>	<p><b>The services listed in this box, delivered to a female Covered Person by a Physician as part of an annual Preventive exam are covered under the Platinum and Gold Benefit Schedules to the extent and under the conditions specified in the Preventive Recommendations:</b></p> <p>Anemia – routine screening for pregnant women.</p> <p>Bacteriuria-- urinary tract or other infection screening for pregnant women.</p> <p>BRCA counseling and genetic testing -- for women at higher risk.</p> <p>Breast Cancer Mammography screenings – one baseline screening between age 35-39, then every 1 – 2 years for women over 40.</p> <p>Breast Cancer Chemoprevention counseling and risk reducing medication without cost share for women at higher risk.</p> <p>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.</p> <p>Cervical Cancer -- screening for sexually active women.</p> <p>Chlamydia Infection -- screening for younger women and other women at higher risk.</p> <p>Contraception: Food and Drug Administration –approved contraceptive methods, sterilization procedures (tubal ligation) and patient education and counseling, Oral contraceptives and some implantable are covered only under the Prescription Drug Benefit.</p>	<p><b>Limitations:</b></p> <p>A listed service or supply is covered once each calendar year, unless otherwise stated.</p>

	<p>Domestic and interpersonal violence screening and counseling.</p> <p>Folic Acid supplements for women who may become pregnant.</p> <p>Gestational diabetes screening -- for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes.</p> <p>Gonorrhea screening -- for all women at higher risk.</p> <p>Hepatitis B screening -- for pregnant women at their first prenatal visit.</p> <p>Human Immunodeficiency Virus (HIV) -- screening and counseling for sexually active women.</p> <p>Human Papillomavirus (HPV) DNA Test -- high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.</p> <p>Osteoporosis screening -- for women over age 60 with specified risk factors</p> <p>Rh incompatibility screening -- for all pregnant women and follow-up testing for women at higher risk.</p> <p>Tobacco Use -- expanded counseling for pregnant tobacco users, in addition to benefits described above for all adults.</p> <p>Sexually Transmitted Infections (STI) -- counseling for sexually active women.</p> <p>Syphilis screening -- for all pregnant women or other women at increased risk.</p> <p>Well-woman office visits to obtain covered Preventive services.</p>	
<p><b>Covered Preventive Services for Children</b></p>	<p><b>The services and supplies listed in this box, delivered to a Covered Person under the age of 19 unless otherwise stated, by a Physician as part of an annual Preventive exam are covered under the Platinum and Gold Benefit Schedules to the extent and under the conditions specified in the Preventive Recommendations:</b></p> <p>Alcohol and Drug Use assessments for adolescents.</p> <p>Autism screening for children at 18 and 24 months.</p> <p>Behavioral assessments</p> <p>Blood Pressure screening.</p> <p>Cervical Dysplasia screening for sexually active females.</p> <p>Congenital Hypothyroidism screening for newborns.</p> <p>Depression screening for adolescents.</p> <p>Developmental screening for children under age 3, and surveillance through childhood.</p> <p>Dyslipidemia screening for children at higher risk of lipid disorders.</p>	<p><b>Limitations:</b></p> <p>A listed service or supply is covered once each calendar year, unless otherwise stated.</p> <p>.</p>

	<p>Fluoride Chemoprevention supplements for children without fluoride in their water source – covered only under the Prescription Drug Benefit.</p> <p>Gonorrhea Preventive medication for the eyes of all newborns.</p> <p>Hearing screening for all newborns.</p> <p>Height, Weight and Body Mass Index measurements.</p> <p>Hematocrit or Hemoglobin screening.</p> <p>Hemoglobinopathies or sickle cell screening for newborns.</p> <p>HIV screening for adolescents at higher risk.</p> <p>Immunization in specified doses, for specified ages and populations :</p> <ul style="list-style-type: none"> <li>• Diphtheria, Tetanus, Pertussis</li> <li>• Haemophilus influenza type B</li> <li>• Hepatitis A</li> <li>• Hepatitis B</li> <li>• Human Papillomavirus</li> <li>• Inactivated Poliovirus</li> <li>• Influenza (flu shot)</li> <li>• Measles, Mumps, Rubella</li> <li>• Meningococcal</li> <li>• Pneumococcal</li> <li>• Rotavirus</li> <li>• Varicella</li> </ul> <p>Iron supplements for children ages 6 to 12 months at risk for anemia.</p> <p>Lead screening for children at risk of exposure.</p> <p>Medical History of all children throughout development.</p> <p>Obesity screening and counseling.</p> <p>Oral Health risk assessment for young children</p> <p>Phenylketonuria (PKU) screening for this genetic disorder in newborns.</p> <p>Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.</p> <p>Tuberculin testing for children at higher risk of tuberculosis.</p> <p>Vision screening.</p>	
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### 3. General Medical Exclusions and Limitations

Irrespective of all other provisions, no medical benefits will be paid for or in connection with:

- a. 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 that is needed to provide safe, adequate and appropriate diagnosis or treatment, except those services and supplies expressly noted in Subsections C.1 and C.2 above as being covered regardless whether Medically Necessary.

- b. Any service or supply that is not a covered service or supply, or that directly or indirectly results from receiving a non-covered service or supply.
- c. 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 Act, Occupational Disease policy or similar law (including settlement of a claim).
- d. Any service or supply provided by a close relative or a person who resides with the Covered Person.
- e. Any treatment for a Sickness or Injury or other condition that is court-ordered, or is a condition of probation or parole.
- f. 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.
- g. A service or supply rendered outside the scope of any Provider's license.
- h. Acupuncture services and associated expenses of any kind, including but not limited to treatment of painful conditions or for anesthesia purposes.
- i. Allergy Services – Those 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.
- j. Alternative Therapies – Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing.
- k. Autopsy – Those services and associated expenses related to the performance of autopsies.
- l. Biofeedback.
- m. Braces or supports needed solely for athletic participation or employment.
- n. Charges that are over 12 months old from the incurred date when submitted for consideration to the Plan.
- o. 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.
- p. Christian Science Practitioners – Christian Science Practitioners' services, with the exception of the Medicare certified Religious Non-Medical Health Care Institutions services.
- q. Cosmetic or reconstructive procedures and any related services or supplies which alter appearance but do not restore or improve impaired physical function, except as expressly listed in Subsection C.1 above.
- r. Counseling – Services and treatment related to religious counseling, marital and relationship counseling, vocational or employment counseling and sex therapy, except as expressly listed in Subsection C.1 above or as provided in the Member Assistance Plan.
- s. Custodial Care not rendered during a covered inpatient admission, including but not limited to non-medical domiciliary care, respite care, rest care, or similar services that primarily assist Covered Persons in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, using the toilet. Also excluded except during a covered inpatient admission are preparation of special diets, supervision of medication 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.
- t. Educational Services – Educational services for remedial education or Developmental Therapy.
- u. Equipment or services for use in altering air quality or temperature.

- v. Elective or Voluntary Enhancement – Elective or voluntary enhancement procedures, services, and medications provided to improve weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging 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 whether Plan benefits were paid to treat the condition that caused the scars.
- w. Electrical continence aids, anal or urethral.
- x. Enteral Feeding Food Supplement – The cost of outpatient enteral tube feedings or formula and supplies, except as expressly listed in Subsection C.1 above.
- y. 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.
- z. Exercise equipment.
- aa. Eye Glasses and Contact Lenses – provision or fitting of eye glasses or contact lenses, except as expressly listed in Subsection C.1 above.
- bb. Eye Services – Orthoptic, eye exercises, blepharoplasty, radial keratotomy, Lasik and other refractive eye surgery.
- cc. Food or Food Supplements.
- dd. Growth hormone, except as expressly listed in Subsection C.1 above.
- ee. Hair analysis, hair styling, wigs and hair transplants whether or not ordered by a Physician.
- ff. Home Services to help meet personal, family or domestic needs.
- gg. Health and athletic club Membership – Any expenses of enrollment and Membership in a health, athletic or similar club.
- hh. Hearing Services and Supplies –Hearing aids and examinations for prescribing and fitting hearing aids, and hearing therapy.
- ii. Household Equipment and Fixtures – Purchase or rental of household equipment, such as, but not limited to fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds.
- jj. Home obstetrical delivery
- kk. Hypnotherapy.
- ll. Hypnosis.
- mm. Illegal Activity - Injury or Sickness resulting from participation in, or as a consequence of having participated in, any criminal or Illegal Activity or enterprise.
- nn. Immunizations for travel or employment, except as expressly listed in Subsection C.1 above.
- oo. 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.
- pp. Maintenance Therapy.
- qq. Massage therapy.

- rr. Military Health Services – Services and supplies furnished to any Covered Person who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or 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.
- ss. Missed appointment charges or charges for time spent traveling
- tt. Naturopathic or holistic services.
- uu. 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 but for the availability of benefits from the Plan.
- vv. Non-emergency care when traveling outside the United States.
- ww. Over the counter supplies and medications unless expressly listed under covered services and supplies.
- xx. Prescription drugs except as provided through the Prescription Drug Benefit
- yy. Private duty nursing services.
- zz. 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.
- aaa. Smoking cessation programs, except the Plan’s approved program covered as a listed Preventive benefit.
- bbb. Transportation for delivery of home health care.
- ccc. Transsexual surgery and associated charges.
- ddd. 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.
- eee. Weight loss medications and procedures intended primarily for weight loss, unless treatment is Medically Necessary due to morbid obesity defined by the National Institute of Health (NIH) guidelines.
- fff. Self-Injectable medications, except as covered in the Prescription Drug Benefit.

## **D. Prior Authorization Requirements**

In most cases, a service or supply must be Medically Necessary as a condition of receiving benefits under the Platinum and Gold Benefit Schedules. The Plan specifies certain services and supplies for which Prior Authorization is required as a condition of receiving such benefits. Prior Authorization, also called utilization management, is a determination made by the Plan in advance, as to whether a proposed service or supply is Medically Necessary. The Plan ordinarily bases this determination on advice received from medical professionals, who may be furnished by Network Sponsors or may be independent medical experts retained by the Plan.

Prior Authorization only confirms that a proposed service or supply is considered Medically Necessary for purposes of qualifying for Plan benefits. Prior Authorization alone does not guarantee either coverage, or availability of benefits. Prior Authorization is not intended, and should not be used, as medical advice about the appropriate or advisable course of medical treatment, which remains the exclusive responsibility of the Covered Person and attending Physician.

### **1. Services and Supplies which Require Prior Authorization as a Condition of Benefits under the Platinum and Gold Benefit Schedules**

The following is a summary list of medical services and supplies for which Prior Authorization is required in some or all cases as a condition of payment of any benefit under the Platinum and Gold Benefit Schedules. This requirement is stated with additional detail in Tables C.1 and C.2. In addition, the plan provides a list of all services that require Prior Authorization at [www.carpdc.coventryhealthcare.com](http://www.carpdc.coventryhealthcare.com).

- a. Abortion (Elective)
- b. Advanced Radiology Services
- c. Ambulance service by air and water, or transfers between facilities
- d. Breast pumps, Hospital grade
- e. Brachytherapy
- f. Chemotherapy and Radiation Therapy
- g. Clinical Trials
- h. Cosmetic, Plastic and Related Reconstructive Surgery
- i. Dental Services (when covered under Medical Benefit)
- j. Dialysis
- k. Durable Medical Equipment
- l. Genetic Testing and Counseling
- m. Global Obstetrical Care
- n. Home Health Care Services
- o. Hyperbaric treatment
- p. Inpatient Hospital Care, except maternity admission to a Hospital that does not exceed 48 hours following a vaginal delivery or 96 hours following a Cesarean section
- q. Inpatient, Residential, Intensive Out Patient and Partial Hospitalization Mental and Nervous Disorders and Substance Abuse
- r. Mastectomy
- s. Medical Complications
- t. Newborn Inpatient Care After Discharge of Mother
- u. Orthopedic devices over \$500
- v. Outpatient Diagnostic Tests and Therapeutic Treatments
- w. Outpatient Surgery
- x. Pain Management Injections

- y. PKU or other Amino and Organic Acid Inherited Disease Formula and Food
- z. Proton Beam Therapy
- aa. Prosthetic Devices and Braces over \$10,000, and refitting or replacements
- bb. CT scans, MRIs, MRAs, PET scans
- cc. Sclerotherapy
- dd. Sleep Studies
- ee. Skilled Nursing Facilities
- ff. Sterilization, by outpatient vasectomy
- gg. TMJ treatment – surgical or non-surgical
- hh. Transplants including stem cell and bone marrow transplants

## **2. Prior Authorization Procedures**

The Plan contracts for its Network Sponsors to furnish Prior Authorization advice concerning a proposed service or supply, regardless whether the proposed Provider is an In-Network or a Non-Network Provider. A Prior Authorization request for a proposed service or supply must therefore be directed to the Network Sponsor of the Network whose Providers would be In-Network Providers for that service or supply. In a large majority of cases, this will be the Plan's General Medical Network, but could instead be the Mental Health and Substance Abuse Network or the Transplant Network.

If a Covered Person seeks care from an In-Network Provider, the Provider is responsible for obtaining any required Prior Authorization. The Covered Person will not suffer any loss of benefits if the In-Network Provider fails to request a Prior Authorization.

If a Covered Person seeks care from a Non-Network Provider, the Covered Person is responsible for ensuring that any required Prior Authorization has been obtained. In such case, the Covered Person or attending Physician must request and receive Prior Authorization prior to providing a proposed, non-emergent service or supply by calling the appropriate Network Sponsor, and must furnish all requested information. In case of an Emergency admission to a Hospital, or Emergency treatment of mental or nervous disorders or substance abuse, the call will be timely if made within the next business day. Prior Authorization is satisfied only if certified by the appropriate Network Sponsor.

Prior Authorization granted for a Hospitalization will include an approved level of care or department of the facility, and initial length of stay. After a patient's admission to the Hospital, the attending Physician may request one or more extensions of the length of stay, with information supporting the request. Inpatient Hospital care is not covered by the Plan after the expiration of the length of stay, or for a higher level of care, than that for which Prior Authorization was granted.

The Plan, in its discretion, may act upon Prior Authorization advice received from the appropriate Network Sponsor, or may request a second opinion from an independent professional source.

## **3. Consequences of Failure to Obtain Required Prior Authorization**

The Plan will pay no benefits for a service or supply if Prior Authorization is denied.

The Plan will deny a claim for benefits if a timely request was not made and granted for Prior Authorization of a service or supply obtained from a Non-Network Provider, except under the circumstances that would make obtaining Prior Authorization impossible or could seriously jeopardize the life or health of the Claimant. If, within 60 days following such denial, the Covered Person provides evidence satisfactory to the Trustees of good cause for the failure to make a timely request, the Plan will conduct a retrospective review and determination whether the service or supply in question was Medically Necessary. The claim denial will stand as the Plan's initial claim determination in the absence of such good cause shown, or if the service or supply is determined on retrospective review not to have been Medically Necessary. If the service or supply is determined on retrospective review to have been Medically Necessary, the failure to make a timely request will be waived.

## **E. Medical Care Management**

The Plan maintains programs designed to provide education, support and coordination services to Members and Dependents. Participation in these programs is elective. There is no charge for participation, and no loss of benefits for electing not to participate.

**1. High Risk Pregnancy**

The Plan's High Risk Pregnancy Care program is available to Covered Persons at any stage of Pregnancy. It is designed to improve the prenatal care of the mother and fetus through education and counseling, in order to reduce the incidence of premature or underweight birth and other complications of Pregnancy and delivery.

**2. Large Case Management**

In selected cases involving complicated, high-risk, or very costly treatment, professional advisers from the Plan's medical Network Sponsors will offer education and advice to the Covered Person with the aim of assisting in selection of alternative courses of treatment and improving the outcome. Case Managers also assist with discharge planning from an inpatient stay.

## Section III

### Prescription Drug Benefit

#### A. Levels of Benefit

The Plan's Prescription Drug Benefit provides benefits for Medically Necessary prescription drugs, and also for some Preventive medications. There are two Prescription Benefit Schedules within the Plan, the Platinum and the Gold Schedules set forth below. This Section III contains terms and conditions applicable to the Platinum and Gold coverages.

#### 1. Platinum Prescription Benefit Schedule

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

PLATINUM PRESCRIPTION BENEFIT SCHEDULE	Plan Coinsurance	Out-of-Pocket Limit**
<b>Retail Pharmacy (30 day supply)</b>		
Generic Medication	90%	Maximum \$50
Preferred Drug Medication	65%	Maximum \$75
Non-Preferred Medication	60%	Maximum \$125
Diabetes and Insulin Supplies	90%	Maximum \$50
<b>Retail Pharmacy (31-90 day supply)</b>		
Generic Medication	90%	Maximum \$125
Preferred Drug Medication	65%	Maximum \$200
Non-Preferred Medication	60%	Maximum \$350
Diabetes and Insulin Supplies	90%	Maximum \$125
<b>Home Delivery (Mail Order) Pharmacy (90 day supply)</b>		
Generic Medication	90%	Maximum \$100
Preferred Drug Medication	65%	Maximum \$150
Non-Preferred Medication	60%	Maximum \$250
Diabetes and Insulin Supplies	90%	Maximum \$100
<b>Specialty Medications</b>		
Preferred Drug Medication	65%	\$150
Non-Preferred Medication	60%	\$250
<b>Specialty Medications approved by FDA on and after 1/1/2013*</b>	50%	No Maximum
<b>Individual Annual Out-of-Pocket</b>		\$2,000
<b>Family Annual Out-of-Pocket</b>		\$6,000

\* Specialty medications approved by FDA on or after 1/1/2013 may be assigned preferred or non-preferred Coinsurance levels by the Board of Trustees.

\*\*Per script, except Family Annual Out-of-Pocket.

#### 2. Gold Prescription Benefit Schedule

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

GOLD PRESCRIPTION BENEFIT SCHEDULE	Plan Coinsurance	Out-of-Pocket Limit**
<b>Retail Pharmacy (30 day supply)</b>		
Generic Medication	80%	Maximum \$50
Preferred Drug Medication	65%	Maximum \$75
Non-Preferred Medication	60%	Maximum \$125
<b>Retail Pharmacy (31-90 day supply)</b>		
Generic Medication	80%	Maximum \$125
Preferred Drug Medication	65%	Maximum \$200
Non-Preferred Medication	60%	Maximum \$350
<b>Home Delivery (Mail Order) Pharmacy (90-day supply)</b>		
Generic Medication	80%	Maximum \$100
Preferred Drug Medication	65%	Maximum \$150
Non-Preferred Medication	60%	Maximum \$250

<b>Specialty Medications</b>		
Preferred Drug Medication	65%	\$150
Non-Preferred Medication	60%	\$250
<b>Specialty Medications approved by FDA on and after 1/1/2013*</b>	50%	No Maximum
<b>Individual Annual Out-of-Pocket</b>		\$2,000
<b>Family Annual Out-of-Pocket</b>		\$6,000

\* Specialty medications approved by FDA on or after 1/1/2013 may be assigned preferred or non-preferred Coinsurance levels by the Board of Trustees.

\*\*Per script, except Family Annual Out-of-Pocket.

As shown in the above Schedules, benefits are higher for generic than for brand name drugs, and within brand name, benefits are higher for preferred medications, which are those listed on the Plan's formulary, than for non-preferred medications. The Plan adopts as its formulary the formulary recommended by its Pharmacy Benefit Manager and Network Sponsor.

## B. Covered Drugs

### 1. General Conditions of Platinum and Gold Coverage

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

- a. Prescribed by a Physician, in all cases;
- b. Legally required to be prescribed, except medications available over the counter (OTC) without prescription that are expressly covered in the Plan;
- c. FDA approved for the condition for which prescribed;
- d. Medically Necessary, except as otherwise expressly stated in the Plan; and
- e. Obtained from an In-Network Provider, except for Emergency care when an In-Network Provider is not reasonably accessible as determined by the Trustees.

Insulin syringes and test strips are treated as required to be prescribed, whether or not available OTC.

Compound medications are covered only if approved in advance under criteria established by the Plan's prescription drug Network Sponsor, which are adopted and included by reference. A request for approval must be submitted to the Network Sponsor, and will not be considered if lacking any of the following elements:

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

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

### 2. Services and Supplies Covered as Preventive Medications

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

- a. only if prescribed by a Physician;
- b. only if obtained from an In-Network Provider;
- c. regardless whether legally required to be prescribed; and
- d. regardless of Medical Necessity, unless otherwise stated Benefits for Preventive services and supplies listed in this table are payable without cost sharing; i.e., payable at a 100% Coinsurance rate without any deductible or Copayment. Inclusion of a service or supply in this table, alone, does not guarantee that benefits are payable.

The drugs, services and devices listed in the following table 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 Preventive Recommendations are incorporated herein by reference, and the provisions of this Subsection B.2 shall be interpreted accordingly. The table that follows shall be automatically amended as necessary from time to time to conform to future changes in the Preventive Recommendations.

Drug or Drug Category	Criteria for Coverage	Limitations
Aspirin prescribed to prevent cardiovascular events	Men ages 45 – 79; Women ages 55 – 79 years	Generic OTC Products
Oral Fluoride	Children > 6 months of age through 5 years old	Generic OTC & RX Products
Folic Acid	Women through age 50 years	Generic OTC & RX Products
Iron Supplements	Children ages 6 to 12 months at risk for iron deficiency anemia	Generic OTC & RX Products
Smoking Cessation	Men & Women age 18 and over who use tobacco products	Must be enrolled in Plan’s Smoking Cessation Program, Generic OTC & RX Products
Vitamin D	Men and Women age 65 and over who are at increased risk for falls	Generic OTC & RX Products
Bowel Preps	Men and Women; >49 years of age and <76 years of age	Generic OTC and RX Products Fill Limit: 2 prescriptions per 365 days
Contraceptives – Hormonal	Women through the age of 50 years	Generic or single source where generic unavailable, including oral, transdermal, intravaginal, injectable and implantable.
Contraceptives – Barrier	Women through the age of 50 years	Diaphragm and Cervical Cap
Emergency Contraceptive	Women through the age of 50 years	Generic and Ella

### C. Special Coverage Limitations

The Plan’s coverage of certain drugs and drug classes is subject to additional conditions and limitations described in this Subsection C.

#### 1. First Line Treatment Programs

For the drug classes listed below, drugs specified as Second Line are not covered unless the patient has first tried a prescribed course of drugs specified as First Line without medically satisfactory results or documented adverse reaction or contraindication to the First Line drug; provided, however, that Second Line drugs prescribed and used by a Covered Person before January 1, 2006 will continue to be covered for that individual without a First Line trial.

##### a. Anti-Arthritic Oral Drugs

- Second Line: COX-2 medications such as Celebrex
- First Line: A traditional Non-Steroidal Anti-Inflammatory agent (NSAID) such as Ibuprofen

##### b. Anti-Arthritic Injectable

- Second Line: Enbrel or Humira
- First Line: Methotrexate or other disease-modifying anti-rheumatic drug (DMARD)

##### c. Anti-Hypertensives

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

#### 2. 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.

**a. 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.

**b. 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:

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

**c. 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:

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

**3. Step Therapy Programs**

- a. Selective Serotonin Reuptake Inhibitors prescribed for depression are not covered unless the patient has first tried a prescribed course of generic citalopram without medically satisfactory results.
- b. Drugs prescribed for osteoporosis are not covered unless the patient has first tried a prescribed course of generic bisphosphonate without medically satisfactory results.
- c. Nasal steroids are not covered unless the patient has first tried a prescribed course of generic fluticasone or Nasonex without medically satisfactory results.
- d. 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.
- e. Topical and oral testosterone medications are not covered unless the patient has first tried a prescribed course of testosterone injections without medically satisfactory results. If satisfactory results are not obtained from injectables, Testim gel or androderm patch may be considered for coverage.

**4. Drug-Specific Limitations**

When coverage of a drug or drug class is limited to generic drugs, coverage will be extended to a brand drug for no more than one year at a time if the attending Physician presents clinical documentation demonstrating that the patient cannot tolerate the generic form, and if Prior Authorization is obtained for the brand drug. For purposes of the Plan, a “new prescription” of a drug is the patient’s first prescription for the drug, or the first prescription of the drug after an interval of at least six months during which the patient has neither taken the drug nor refilled a prescription for the drug.

**a. Stomach (gastric) acid reduction Proton Pump Inhibitors (PPI)**

Only generic drugs are covered. A new prescription for PPI is limited to 8 weeks of therapy, unless clinical documentation is provided supporting one of the following diagnoses for which continued therapy is Medically Necessary:

- 1) Severe GERD
- 2) Zollinger Ellison Syndrome
- 3) Schatski's Ring
- 4) Barret's Esophagitis
- 5) GI Cancers
- 6) Chronic Erosive Esophagitis

**b. Cholesterol (lipid) lowering drugs**

Only generic drugs are covered, except Crestor 40 mg will also be covered for Covered Persons with excessively high cholesterol levels for which a dosage of 40 mg or more is Medically Necessary.

**c. Antidepressants**

Only generic drugs are covered, unless the prescribing Physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to not be effective, or to cause an adverse reaction in the patient.

**d. Antipsychotics**

Only generic drugs are covered, and for children under the age of 5 years, only with Prior Authorization. Brand drugs are covered only if the prescribing Physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to not be effective, or to cause an adverse reaction in the patient.

**e. Attention Deficit (CNS Stimulants)**

Only generic drugs are covered, and for Covered Persons over the age of 18 years, only with Prior Authorization. If more than one CNS stimulant is prescribed at the same time, only one will be covered. Brand drugs are covered only if the prescribing Physician demonstrates that all appropriate generic medications were tried at various dosage levels and determined to not be effective, or to cause an adverse reaction in the patient.

**f. Pain Medications**

- 1) Products containing acetaminophen are covered only for prescribed cumulative daily dosage of 4 g or less.
- 2) Oxycodone coverage is limited to 180 mg daily maximum.
- 3) Oxymorphone coverage is limited to 120 mg daily maximum.
- 4) Hydromorphone coverage is limited to 24 mg daily maximum.
- 5) Oxycontin is covered only after a 60-day trial and failure of each of the following: morphine ER (extended release), methadone, fentanyl patches, and oxymorphone ER and limited to a treatment period of 90 days. Prescriptions are covered from only one prescriber at a time, and are further limited to 90 pills per 30-day period per cumulative strength. After exhaustion of a 90-day supply, one further fill for up to 3 days will be covered if prescribed during a visit to an Emergency room or urgent care facility.

**g. Suboxone**

Covered only when prescribed for opioid dependence with accompanying Physician's treatment plan. Coverage is limited to one year.

**h. PCSK9 drugs**

PCSK9 drugs, generic or brand name, are covered as specialty drugs, only when the patient's medical records show that all of the following criteria have been satisfied: prescribed by a cardiologist; Familial Hypercholesterlia confirmed and documented; the patient has tried high-intensity statin therapy with resulting baseline fasting lipid levels greater than 100 mg/dl or 190 mg/dl if statin intolerant; and patient has tried and failed at least one non-statin therapy for 6 months. If criteria are satisfied, initial coverage is for 3 months; if successful, continuing coverage is for 12 months.

**i. Orkambi, lumacaftor/vacaftor**

Covered as specialty drug, only when the patient's medical records show that all of the following criteria have been satisfied: prescribed by a pulmonologist; documentation of 2 copies of F508del mutation. If criteria are satisfied, initial coverage is for 6 months, with continued coverage dependent on response reassessed at that time.

**j. Jadenu, deferasirox**

Covered as specialty drug, only for FDA indication, and only when the patient's medical records show that all of the following criteria have been satisfied: serum creatinine clearance, serum transaminases and bilirubin are satisfactory per Black Box Warning; if patient has hepatic impairment, Child-Pugh class must not be severe (class C) and dosage must be reduced if moderate (Class B). If criteria are satisfied, initial coverage depends on quarterly documentation of serum transaminases and bilirubin every two weeks during the first month and at least monthly thereafter for the first year.

**k. Lenvima, lenvatinib**

Covered as specialty drug, only when the patient's medical records show that all of the following criteria have been satisfied: prescribed by an oncologist; covered only for treatment of differentiated thyroid cancer.

#### **D. Excluded Drugs**

The Plan does not provide any prescription drug benefits under the Platinum and Gold Schedules for the following:

1. Non-sedating antihistamines (NSAs).
2. Medications available without prescription over the counter, except as expressly noted in the Plan.
3. Any drug if and after the patient has failed to comply with or complete the covered course of treatment prescribed for that drug.
4. Drugs intended for use in a Physician's office or intended as samples.
5. Immunization agents, biological serum, vaccines, or biologicals covered under the Medical Benefit.
6. Experimental or Investigative drugs.
7. Drugs a Covered Person is eligible to receive without charge under any workers' compensation law, or any municipal, state or federal program.
8. Rogaine, Renova, Propecia, or any other medication prescribed for the treatment of hair loss.
9. Zyban and other smoking cessation agents, such as gum, patches and nasal spray including Nicorette, Habitrol, Nicoderm, Nicotrol, and ProStep, unless provided through a smoking cessation program approved by the Plan.
10. Weight loss medications.
11. Tri-Vi-Flor and other pediatric vitamins containing fluoride (except for children older than 6 months of age through 5 years old).
12. Any dental products, including fluoride preparations and rinses such as Luride and Phos-Flur (except for children older than 6 months of age through 5 years old).
13. Drugs used to enhance or improve fertility.
14. Anabolic steroids, including Anadrol, Oxandrin, and Winstrol.
15. Any drugs, services or devices that do not satisfy the General Conditions of Platinum and Gold Coverage set forth in Subsection B.1 above.
16. Drugs not FDA approved for the condition for which prescribed.
17. Testosterone for female patients.
18. KyBella
19. Tuzistra XR
20. Toujeo

21. Farydak
22. Natpara
23. Glumetza

## **E. Network Providers**

Except for Emergency care described below, the Plan pays prescription drug benefits only for drugs obtained from an In-Network Provider. In the Platinum and Gold coverages, all specialty prescriptions must be filled by the Specialty Network to be covered, except that a specialty drug that is a limited distribution drug may be obtained from the approved issuing pharmacy. At the date of this restated Plan Document, Express Scripts is the Network Sponsor for the retail Network and Home Delivery Network. The specialty drug Network is known as Diplomat Pharmacy.

As a limited exception to the In-Network requirement, the Plan will cover a drug from a Non-Network Provider to the extent Medically Necessary for Emergency care when an In-Network Provider is not reasonably accessible as determined by the Trustees.

### **1. Retail Pharmacy Network**

In general, the Plan covers up to a 30-day supply of drugs, other than maintenance or specialty drugs, obtained from a Provider in the Retail Pharmacy Network. The Plan covers up to a 90-day supply of maintenance drugs obtained from a Provider in the Retail Pharmacy 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.

### **2. Home Delivery Network**

The Plan covers up to a 90-day supply of maintenance drugs, and up to a 30-day supply of other drugs except specialty drugs, when obtained from the Home Delivery Network, except 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, and diabetes.

### **3. 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 specialty drug that is a limited distribution drug may be obtained from the approved issuing pharmacy. Specialty drugs are generally high-cost medications for treatment of patients with refractive conditions such as oncology, psoriasis, Crohn's disease, rheumatoid arthritis, hepatitis, multiple sclerosis, HIV/AIDS, growth hormone deficiency, organ transplant, fertility, and hemophilia. All newly prescribed specialty drugs require Prior Authorization.

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 adopts and incorporates by reference the criteria of the Diplomat Pharmacy to identify specialty drugs that have a high risk of intolerance or serious adverse effects warranting short-fill trials. The current list of such drugs is available by inquiry to the Plan Office or on the Plan website at [www.carpdc.org/Benefits](http://www.carpdc.org/Benefits). 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.

## **F. Prior Authorization Requirements**

As in the case of services and supplies within the Medical Benefit, the Plan specifies certain drugs or quantities for which Prior Authorization is required as a condition of receiving any prescription drug benefit. Prior Authorization, also called utilization management, is a determination made by the Plan in advance, as to whether a proposed drug is Medically Necessary. The Plan ordinarily bases this determination on advice

received from medical professionals, who may be furnished by Network Sponsors or may be independent medical experts retained by the Plan.

Prior Authorization only confirms that a proposed drug is considered Medically Necessary for purposes of qualifying for Plan benefits. Prior Authorization alone does not guarantee either coverage, or availability of benefits. Prior Authorization is not intended, and should not be used, as medical advice about the appropriate course of medical treatment, which remains the exclusive responsibility of the Covered Person and attending Physician.

The Plan contracts for its prescription drug Network Sponsor to furnish Prior Authorization advice concerning a proposed drug. In-Network Providers are responsible for obtaining any required Prior Authorization for drugs they dispense. Because the Prescription Drug Benefit is generally limited to In-Network Providers, a Covered Person is not required to initiate a request for Prior Authorization except in the case of a drug administered in the course of Emergency care when an In-Network Provider is not reasonably accessible as determined by the Trustees.

In the case of such emergent care, the Covered Person or attending Physician must request Prior Authorization by calling the Plan's prescription drug Network Sponsor no later than the next business day. Prior Authorization is satisfied only if certified by the Network Sponsor.

If a Covered Person fails to make timely request for Prior Authorization of a drug obtained from a Non-Network Provider, no benefits will be paid for such drug unless the Covered Person demonstrates good cause for the untimely request, is granted retrospective review of Medical Necessity, and establishes Medical Necessity, according to the procedure set forth in Section II.D.3.

Either at the time of an initial benefit determination, or on retrospective review or Appeal, the Plan, in its discretion, may act upon Prior Authorization advice received from the Network Sponsor, or may request a second opinion from an independent professional source.

## **G. Amount of Benefit**

For coverage under the Platinum and Gold Schedules, the Allowable Amount for a script is the lesser of the amount charged or the uniform charge that the Provider has agreed to accept as a Member of the Network. No deductibles or Copays are applicable. If a drug obtained in an Emergency from a Non-Network Provider is covered, the Allowable Amount is the amount charged, not to exceed the lesser of Average Wholesale Price and Maximum Allowable Cost as determined by the Network Sponsor, and reduced as necessary to conform to any other specific limitations set forth in the Plan.

The Plan will pay the Allowable Amount multiplied by the Coinsurance rate set forth in the applicable Schedule of Benefits, and the Covered Person must pay a Coinsurance share equal to the balance of the Allowable Amount for the script. However, when a Covered Person has paid a Coinsurance share equal to the per-script Out-of-Pocket Maximum, the Plan's applicable Coinsurance rate becomes 100% for the balance of the Allowable Amount.

For coverage under the Platinum and Gold Schedules, when the combined amount of Coinsurance share payments made in a calendar year by any individual Covered Person equals the Individual Annual Out-of-Pocket maximum, the Plan's Coinsurance rate becomes 100% for all covered prescriptions filled during the same calendar year for the same Covered Person, irrespective of whether the Family Annual Out-of-Pocket maximum has been attained.

For coverage under the Platinum and Gold Schedules, when the combined amount of Coinsurance share payments made in a calendar year by any combination of a Member and the Member's Dependents equals the Family Annual Out-of-Pocket Maximum, the Plan's Coinsurance rate becomes 100% for all covered prescriptions filled during the remainder of the same calendar year for the Member and all of the Member's Dependents.

## Section IV

### Dental Benefit

#### A. Eligibility

The Plan's Dental Benefit is provided automatically, without additional contributions or Premium, to Members in the Active Classification and their Dependents. The Dental Benefit is available as an optional coverage, at an additional Premium determined periodically by the Trustees, 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 at the time of enrollment in the UHC Medicare Advantage Program, or during an Open Enrollment period of October 1 through December 15 of each year. If the Dental Benefit is dropped after having been elected, it may not be reinstated.

The Dental Benefit is self-funded by the Plan. The Plan has contracted with Delta Dental, LLP to process dental claims, and for access to the Dental Network. Therefore, all claims for dental benefits must be submitted directly to Delta Dental, regardless whether from In-Network or Non-Network Providers.

#### B. Covered Dental Services and Supplies

Procedures are covered for benefits only if they are:

1. Billed using approved American Dental Association (ADA) codes;
2. Performed by a licensed Dentist (DDS or DMD), or by a licensed dental hygienist under the supervision of a Dentist;
3. Within the standard of care of the dental profession, as determined by the Plan;
4. Medically Necessary, except if listed as "Preventive;" and
5. Not excluded or limited by the provisions of this Section IV.

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
<b>PREVENTIVE SERVICES</b>	
Diagnostic and Preventive Services	Services and procedures used to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Includes oral examination, prophylaxes (cleanings) and topical applications of fluoride. <ul style="list-style-type: none"><li>• Oral examinations and prophylaxes (cleanings) performed twice in a calendar year; if Medically Necessary, prophylaxes can be covered for up to four times per calendar year.</li><li>• Fluoride treatments performed twice in a calendar year for patients up to age 19.</li><li>• Brush biopsy to detect oral cancer.</li></ul>
Emergency Palliative Treatment	Nonspecific treatment used on an emergency basis to temporarily relieve pain.
Radiographs	X-rays as required or in conjunction with the diagnosis of a specific condition. <ul style="list-style-type: none"><li>• Bi-wing radiographs performed twice in a calendar year.</li><li>• Full-mouth radiographs (which includes bitewing X-rays) performed once every three- years.</li></ul>

Healthy Smiles, Healthy Lives Program	Two additional cleanings per calendar year for individuals with documented periodontal disease, diabetics with periodontal disease, pregnant women with periodontal disease, individuals with certain high-risk medical conditions such as kidney failure, organ or bone marrow transplant recipients, individuals receiving dialysis, chemotherapy, radiation treatment, individuals who are HIV positive or are at risk for infective endocarditis.  For individuals age 19 and older undergoing head and neck radiation, fluoride applications are covered twice per calendar year.
<b>BASIC BENEFITS</b>	
Sealants	Applied to the occlusal surface of molars that are free from caries and restorations, once per tooth per lifetime.  • Benefits are payable for first and second permanent molars up to age 19 only
Oral Surgery Services	Extractions and other surgical dental procedures; includes pre-operative and post-operative care.
Endodontic Services	Procedures used for the treatment of teeth with diseased or damaged nerves (root canals).
Periodontic Services	Procedures used for the treatment of diseases of the gums and supporting structures of the teeth including gum disease. This includes periodontal maintenance following active therapy (periodontal prophylaxes).
Minor Restorative Services	Services used to rebuild, repair, or reform the tissues of the teeth; includes amalgam, restorations (repair of crowns, or onlays), resin restorations, and relines and repairs to prosthetic appliances (bridgework and dentures).
<b>MAJOR BENEFITS</b>	
Prosthodontic Services	Services and appliances that replace missing natural teeth; includes fixed bridgework, partial dentures, complete dentures and implants at the alternate treatment allowable.
Major Restorative Services	Services used to rebuild, repair or reform the tissues of the teeth when the teeth cannot be restored with another filling material, includes replacement of cast restoration (crowns), and jackets.
<b>ORTHODONTIC BENEFITS</b>	
Orthodontic Services	Services, treatment and procedures required for the correction of malposed teeth.

## C. Levels of Benefit

### 1. Network Providers

The Plan's contracted Network Sponsor at the date of this restated Plan Document is Delta Dental of Missouri for covered dental services. Covered Persons have access to the Delta Dental PPO Network and the Delta Dental Premier Network. Covered Persons are free to choose to obtain covered services and supplies from Providers in the PPO or Premier Networks or from Non-Network Providers. The Plan allows for higher benefits for Providers in the PPO Network than for Providers in the Premier Network or Non-Network Providers.

In-Network dental Providers are named and updated on a list maintained at the Plan Office and on the Delta Dental website at [www.deltadentalmo.com/carpdc](http://www.deltadentalmo.com/carpdc).

## 2. Deductibles, Coinsurance and Maximum Benefit Limits

There are three levels of dental benefits payable for Covered Services, as set forth in the following table:

LIMITATION	PPO NETWORK	PREMIER NETWORK	NON-NETWORK
Annual Deductible, Preventive Services*	None	\$50	\$75
Annual Deductible, All Other Services, Cumulative	\$50	\$75	\$75
Plan Coinsurance, Preventive Services	100%	75%	50%
Plan Coinsurance, Basic Services	80%	50%	25%
Plan Coinsurance, Major Services	50%	40%	25%
Plan Coinsurance, Orthodontic Services	50%	50%	50%
Annual Maximum Benefit, excluding Orthodontia*	Max Advantage plus \$1,500	Max Advantage plus \$1,500	Max Advantage plus \$1,500
Lifetime Maximum Benefit, Orthodontia Only	\$1,500	\$1,500	\$1,500

\*Per Covered Person, except for Dependent child prior to 19<sup>th</sup> birthday.

The annual dental deductible is the amount of covered dental expenses each Covered Person must pay each calendar year before receiving any dental benefits from the Plan. The deductible is waived for Preventive services obtained by a Dependent child prior to 19<sup>th</sup> birthday from any Provider, and for Preventive services obtained by any Covered Person from a Delta Dental PPO Provider. The deductible paid for Preventive services counts towards the deductible for all other services, but not vice versa.

The annual maximum benefit payable by the Plan for all covered dental services except orthodontia incurred in a calendar year for each Covered Person is \$1,500 plus Max Advantage benefits, but this limit does not apply to Dependent children before their 19<sup>th</sup> birthday for Preventive dental services.

The lifetime maximum benefit for covered orthodontia expenses incurred by a Covered Person is \$1,500. Medically Necessary orthodontia for individuals up to age 19 years is not subject to the orthodontia lifetime maximum. Medically Necessary orthodontia must be reviewed and approved by the Network Sponsor.

## 3. Max Advantage

The Max Advantage feature means that the Annual Maximum Benefit limit does not include the Covered Services listed below:

CDT CODE	DESCRIPTION
D00120	Periodic Oral Evaluation
D00140	Limited Oral Evaluation
D00145	Oral Evaluation for a Patient under three years of age and counseling with Primary Caregiver
D00150	Comprehensive Oral Evaluation
D00160	Detailed and Extensive Oral Evaluation
D00180	Comprehensive Periodontal Evaluation

D00210	Intraoral - complete series of radiographic images
D00220	Intraoral - periapical first radiographic image
D00230	Intraoral – periapical each additional radiographic image
D00240	Intraoral – occlusal radiographic image
D00250	Extraoral - first radiographic image
D00260	Extraoral – each additional radiographic image
D00270	Bitewing – single radiographic images
D00272	Bitewings – two radiographic images
D00273	Bitewings – three radiographic images
D00274	Bitewings – four radiographic images
D00277	Vertical bitewings 7 – 8 radiographic images
D00290	Posterior – anterior or lateral skull and facial bone survey radiograph image
D00330	Panoramic radiographic image
D01110	Prophylaxis – adult
D01120	Prophylaxis – child
D01206	Topical application of fluoride varnish
D01208	Topical application of fluoride –excluding varnish
D04910	Periodontal maintenance

#### 4. Special Accident Benefit

The Plan provides extra coverage for dental treatment of accidental injuries to teeth or restorations. These services are covered only with Prior Authorization, except for Emergency services. Benefits obtained in either the PPO or Premier Network will be paid at 90 % of the allowable amount. Out-of-Network services are subject to the usual and customary limit, and will be paid at 50% of the allowable amount. Services approved and paid under this benefit will not be subject to the annual or lifetime maximums but are subject to the annual individual dental deductible.

#### D. Determination of Benefit Amounts

The Allowable Amount is the maximum benefit that the Plan would pay on a claim if the Coinsurance rate were 100% and if no deductible were applicable. The Plan’s Allowable Amount for an In-Network claim is the uniform charge the Network Provider has agreed to accept as a member of the Network. The Plan’s Allowable Amount for a Non-Network claim is the lesser of the billed charge or the reasonable and customary amount. The reasonable and customary amount applied to Non-Network claims is equal to the Delta Dental PPO contracted rate for the same procedure.

Upon receiving a claim for services and supplies covered under the Dental Benefit, the Plan will subtract from the Allowable Amount the unpaid portion of the claimant’s annual deductible. The result multiplied by

the Plan's coinsurance percentage equals the benefit payable by the Plan; provided, however, that the amount of Plan benefits payable is also subject to all of the following limitations:

1. No benefit will be paid in excess of an applicable annual or lifetime maximum benefit unless specifically noted;
2. No benefit will be paid for dental services performed outside a dentist's office if a required Prior Authorization was not obtained;
3. No benefit will be paid under the Special Accident Benefit if Prior Authorization was not obtained;
4. If there are two or more possible methods of treating a particular dental condition, then regardless which method is employed, benefits are limited to the benefits payable for the least costly treatment within the standard of care; and
5. No benefit will be paid for services and supplies listed in the dental limitations and exclusions set forth in Subsection F.

For In-Network claims, a Covered Person is responsible for the difference between the amount the In-Network Provider has agreed to accept as a Member of the Network and the Plan benefits payable. For Non-Network claims, the Covered Person is responsible for the difference between the billed charge and the Plan benefits payable. Network Providers may not bill an amount in excess of the uniform charge the Provider has agreed to accept as a Member of the Network; whereas Non-Network Providers are not limited in the amount they may charge. There is no Out-of-Pocket limit applicable to the Dental Benefit.

#### **E. Prior Authorization and Predetermination of Benefits**

No Plan benefits are payable for a claim under the Special Accident Benefit, or a claim for covered dental procedures proposed to be performed in an Ambulatory Surgical Center or Hospital, unless Prior Authorization was obtained before commencement of services confirming that both the facility and the procedures are Medically Necessary and within the standard of care. The Plan contracts for Delta Dental to furnish Prior Authorization advice for the Dental Benefit. A Covered Person is responsible for ensuring that required Prior Authorization is obtained for services of a Non-Network Provider. Requests for Prior Authorization must be submitted to Delta Dental. The procedures set forth in sections II.D.2 and II.D.3 above will apply. Prior Authorization alone does not guarantee either coverage, or availability of benefits.

There is no Prior Authorization requirement for other services and supplies covered under the Dental Benefit that are received in an office setting. However, a Covered Person can obtain a predetermination of Plan benefits payable for a proposed course of treatment for which expected charges exceed \$300 if the dentist's treatment program is submitted to Delta Dental before services are performed. The submission should include details of the condition of the patient's mouth, the dentist's proposed services, and the charges for those services. Delta Dental will notify the patient and dentist of its determination of Medical Necessity, any alternative courses of treatment that could affect the benefits payable, and the estimated benefits payable based on the planned course of treatment.

#### **F. Limitations and Exclusions**

Irrespective of all other provisions, no dental benefits will be paid for or in connection with:

1. Services or supplies for which the Covered Person, absent Plan coverage, would normally incur no charge, such as care rendered by a dentist to a Member of his family or the family of his spouse.
2. Services or supplies arising out of the course of any occupation or employment for compensation, profit or gain, or for which the Covered Individual may be entitled to or receives benefits under any applicable Workers' Compensation Act, Occupational Disease policy or similar law (including settlement of a claim).
3. Any service or supply not performed or furnished by a Dentist, except X-rays ordered by a Dentist and services by a licensed dental hygienist under the Dentist's supervision.
4. Services or supplies performed for cosmetic purposes or to correct congenital malformations.
5. Charges that are not reasonably necessary or customarily provided for the Covered Individual's dental condition.

6. Services furnished by or for the U.S. government or any other government unless payment by the patient is legally required, or to the extent provided under any governmental program or law under which the patient is, or could be, covered.
7. A denture or fixed bridgework or adding teeth thereto, or a crown or gold restoration, if the denture, fixed bridge, crown or gold restoration is a replacement or modification of one installed less than five years previously, except when due to an Accidental Injury. If an existing bridge or denture cannot be repaired satisfactory, a replacement will be covered only once in 5 years, provided that the 5-year limitation will not apply to a replacement required to treat accidental Injury that occurred while denture, fixed bridgework, crown or gold restoration was in place.
8. Services or supplies related to temporomandibular joint (TMJ) dysfunction.
9. Duplication or replacement of lost or stolen appliances.
10. Diseases contracted or injuries or conditions sustained as a result of any act of war.
11. Denture adjustments for the first six months after the dentures are initially received.
12. Repair or replacement of an orthodontic appliance.
13. Tooth preparation, temporary crowns, bases, impressions and anesthesia or other services which are part of the complete dental procedure. These services are considered components of, and included in the fee for the complete procedure.
14. Analgesia, including Nitrous Oxide, other than local.
15. Duplication of radiographs or temporary appliances.
16. Any dental services to the extent that benefits are payable under the Medical Benefit of this Plan.
17. Services rendered beyond the scope of the Provider's license, or services or supplies that do not meet accepted standards or dental practice or that are Experimental or Investigative.
18. Oral hygiene and dietary instruction or plaque control programs.
19. Failure to keep a scheduled appointment with the dentist.
20. Completion of claim forms.
21. Charges for personalization or characterization of dentures.
22. Charges for services or supplies 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.
23. Charges for medications, infection control or medical waste disposal.
24. Diagnosis and treatment of an Injury or Sickness resulting from participation in, or as a consequence of having participated in, commission of any felony.
25. Benefits for routine examinations and cleanings are limited to two per calendar year, except as provided in the Healthy Smiles Healthy Lives program. A PPO Network Provider must be used for routine exams and cleanings in order for the Preventive benefit with no deductible to apply.
26. Services or supplies received as a result of any Injury or 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.
27. Charges for fluoride or sealants are limited to Dependents prior to their 19<sup>th</sup> birthday.
28. Coverage for multiple radiographs on the same date of service will not exceed the coverage level for a complete mouth series. A panoramic film, with or without other films, is treated as a full mouth series for coverage purposes.
29. Endodontic (root canal) treatment on the same tooth is covered only once in a 2 year period.
30. 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.

31. If a Covered Person's eligibility is terminated before an orthodontic treatment plan is completed, coverage of the treatment will be provided only to the end of the month of termination.
32. If care is received from more than one Provider for the same procedure, benefits will not exceed what would have been paid to one Dentist for the procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy).
33. Sealants are limited to caries-free occlusal surfaces of the first and second permanent molars.
34. All Coordination of Benefit Rules, definitions, filing limits and other limitations applicable to the medical plan are also applicable to the dental plan.

## **G. Claims for Dental 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 PPO or Premier Network Provider's failure to make timely submission, the Covered Person will not be liable to such Provider for the amount which would have been payable by the Plan, provided the Covered Person advised the Provider of eligibility for Plan benefits at the time of treatment. A Covered Person who obtains services and supplies from a Non-Network Provider is responsible for filing a timely claim for reimbursement with Delta Dental.

## **H. Additional Plan Definitions – Dental**

1. **“Accidental Injury”** means an Injury to a tooth, teeth or restoration caused by a physical Injury resulting from an accident not related to the normal function of the tooth or teeth.
2. **“Delta Dental PPO”** or **“PPO”** means the preferred Provider organization available through Delta Dental of Missouri.
3. **“Dentist”** means a dentist duly licensed and legally qualified to practice dentistry at the time and place covered dental services are performed.
4. **“Premier Dentist”** means a Dentist or service Provider who is a Member of the Delta Dental Premier Network.
5. **“Non-Network Dentist”** means a Dentist or service Provider who is not a Member of either the Delta Dental Premier Network or the Delta Dental PPO Network.
6. **“In-Network Dentist”** means a Dentist or service Provider who is a Member of either the Delta Dental Premier Network or the Delta Dental PPO Network.
7. **“PPO Dentist”** means a Dentist or service Provider who is a Member of the Delta Dental PPO Network.

## Section V

### Schedule of Medical Benefits

#### A. Platinum Plan

BENEFIT	Coventry PPO/ASO & Coventry National Network Providers	Out-of-Network Providers
Annual Deductible	\$200 Individual/\$600 Family	\$600 Individual/\$1,800 Family
Annual Out-Of-Pocket Maximum	\$2,000 Individual/\$6,000 Family	Unlimited
Coinsurance	90%	50%
<b>PREVENTIVE CARE</b>		
Routine Preventive Care	100%	Deductible /50%
Routine Mammogram	100%	Deductible/50%
Routine Colonoscopy	100%	Deductible/50%
<b>OFFICE VISITS – NON ROUTINE</b>		
Primary Care Physician Office Visit	\$25	Deductible/50%
Specialist Office Visit	\$50	Deductible/50%
<b>OUTPATIENT SERVICES<sup>1,3</sup></b>		
Outpatient Surgery <sup>1</sup>	Deductible /90%	Deductible /50%
Lab, Radiology, Anesthesia, Pathology and other Ancillary Services	Deductible /90%	Deductible /50%
CT, PET, MRI Scans, Nuclear Scans and Other Diagnostic Services <sup>1</sup>	Deductible /90%	Deductible /50%
Physical, Speech and Occupational Therapy Services <sup>3</sup>	Deductible /90%	Deductible /50%
Durable Medical Equipment, Orthotics and Prosthetics <sup>1</sup>	Deductible /90%	Deductible / 50%
Home Health Services/ Hospice <sup>1</sup>	Deductible/ 90%	Deductible /50%
Mental Health Substance Abuse Partial, Intensive Outpatient and Electroshock Treatment <sup>1</sup>	Deductible /90%	Deductible /50%
Chiropractic Care (\$1,500 annual benefit maximum cross accumulates among all benefit levels) <b>Effective 5/1/2015</b> Limited to 40 visits annually	Maximum of \$42 per visit through 4/30/15  \$10 Copay	Maximum of \$42 per visit through 4/30/15  No Deductible/50%
<b>INPATIENT SERVICES<sup>1</sup></b>		
Inpatient Hospital Services <sup>1</sup>	Deductible /90%	Deductible /50%
Convalescent Skilled Nursing Facility <sup>1</sup> (Aggregate 100-day maximum cross accumulates among all benefit levels)	Deductible /90%	Deductible /50%
Mental Health Substance Abuse Residential Care <sup>1</sup>	Deductible /90%	Deductible /50%
Observation Room <sup>1</sup>	Deductible /90%	Deductible /50%
Physician Hospital Visits and Specialist Care/Consultations	Deductible /90%	Deductible /50%
Inpatient Ancillary Services (Emergency Room, Radiology, Anesthesiology, Pathology)	Deductible/ 90%	Deductible /50%
<b>EMERGENCY AND URGENT CARE<sup>2</sup></b>		
Hospital Emergency Room <sup>2</sup>	\$250 Copay	\$250
Urgent Care Facility	\$75 Copay	Deductible/50%
Ground Ambulance Service	\$150 Copay	\$150 Copay
Air Ambulance <sup>1</sup>	\$1,000 Copay	\$1,000 Copay

<sup>1</sup>May require pre-certification through the Medical Care Management Company.

<sup>2</sup>Emergency Room Copay waived and deductible/Coinsurance applies in the event patient is admitted through the Emergency Room.

<sup>3</sup>Limited to combination of 60 visits annually.

## B. Gold Plan

BENEFIT	Coventry PPO/ASO & Coventry National Network Providers	Out-of-Network Providers
Annual Deductible	\$300 Individual/\$900 Family	\$800 Individual/\$2,400 Family
Annual Out-Of-Pocket Maximum	\$4,000 Individual/\$7,700 Family	Unlimited
Coinsurance	80%	50%
<b>PREVENTIVE CARE</b>		
Routine Preventive Care	100%	Deductible/50%
Routine Mammogram	100%	Deductible/50%
Routine Colonoscopy	100%	Deductible/50%
<b>OFFICE VISITS – NON ROUTINE</b>		
Primary Care Physician Office Visit	\$25	Deductible/50%
Specialist Office Visit	\$50	Deductible/50%
<b>OUTPATIENT SERVICES<sup>1,3</sup></b>		
Outpatient Surgery <sup>1</sup>	Deductible/80%	Deductible/50%
Lab, Radiology, Anesthesia, Pathology and other Ancillary Services	Deductible/80%	Deductible/50%
CT, PET, MRI Scans, Nuclear Scans and Other Diagnostic Services <sup>1</sup>	Deductible/80%	Deductible/50%
Physical, Speech and Occupational Therapy Services <sup>3</sup>	Deductible/80%	Deductible/50%
Durable Medical Equipment, Orthotics and Prosthetics <sup>1</sup>	Deductible/80%	Deductible/50%
Home Health Services/ Hospice <sup>1</sup>	Deductible/80%	Deductible/50%
Mental Health Substance Abuse Partial, Intensive Outpatient and Electroshock Treatment <sup>1</sup>	Deductible/80%	Deductible/50%
Chiropractic Care (\$1,500 annual benefit maximum cross accumulates among all benefit levels) <b>Effective 5/1/2015</b> Limited to 40 visits annually	Maximum of \$42 per visit through 4/30/15  \$10 Copay	Maximum of \$42 per visit through 4/30/15  No Deductible/50%
<b>INPATIENT SERVICES<sup>1</sup></b>		
Inpatient Hospital Services <sup>1</sup>	Deductible/80%	Deductible/50%
Convalescent Skilled Nursing Facility <sup>1</sup> (Aggregate 100-day maximum cross accumulates among all benefit levels)	Deductible/80%	Deductible/50%
Mental Health Substance Abuse Residential Care <sup>1</sup>	Deductible/80%	Deductible/50%
Observation Room <sup>1</sup>	Deductible/80%	Deductible/50%
Physician Hospital Visits and Specialist Care/Consultations	Deductible/80%	Deductible/50%
Inpatient Ancillary Services (Radiology, Anesthesiology, Pathology)	Deductible/80%	Deductible/50%
<b>EMERGENCY AND URGENT CARE<sup>1,2</sup></b>		
Hospital Emergency Room <sup>2</sup>	\$300	\$300
Urgent Care Facility	\$75	Deductible/50%
Ground Ambulance Service	\$300	\$300
Air Ambulance <sup>1</sup>	\$1,000	\$1,000

<sup>1</sup>May require pre-certification through the Medical Care Management Company.

<sup>2</sup>Emergency Room Copay waived and deductible/Coinsurance applies in the event patient is admitted through the Emergency Room.

<sup>3</sup>Limited to combination of 60 visits annually.

## Section VI

### Vision Benefit

#### A. Eligibility

The primary purpose of the Plan's Vision Benefit is to assist eligible Members and Dependents to obtain eyeglasses or contact lenses to improve visual acuity. The Vision Benefit is provided automatically, without additional contributions or Premium, to eligible Members and Dependents not enrolled in the UHC Medicare Advantage Program

The Plan has contracted with Vision Service Plan (VSP) to process claims in the Vision Benefit, to make Prior Authorization determinations, and for access to a vision Network. Therefore, all claims for vision benefits must be submitted directly to VSP, regardless whether from In-Network or Non-Network Providers.

#### B. Levels of Benefit

##### 1. Network Provider

The Plan's Network at the date of this restated Plan Document, for purposes of the Vision Benefit, is the Vision Service Plan (VSP) Network. Covered Persons are free to choose to obtain covered services and supplies from In-Network Providers or from Non-Network Providers. In general, Plan benefits are higher for In-Network Providers than for Non-Network Providers.

In-Network vision Providers are named and updated on a list maintained at the Plan Office and on the VSP website at [www.vsp.com](http://www.vsp.com).

##### 2. Copayments and Maximum Benefit Limits

There are two levels of vision benefits, In-Network and Non-Network, as set forth in the following table:

SERVICE OR SUPPLY	MAXIMUM FREQUENCY	VSP PROVIDER COPAYMENT	VSP PROVIDER MAXIMUM BENEFIT*	NON-VSP PROVIDER MAXIMUM BENEFIT*
Eye Examination	12 Months	\$10	Network Schedule	\$38
Eyeglass Frames	24 Months	\$25	Network Schedule	\$45
Eyeglass Lenses (one pair) <ul style="list-style-type: none"> <li>• Single Vision</li> <li>• Lined Bifocal</li> <li>• Lined Trifocal</li> <li>• Lenticular</li> </ul>	12 Months	None	Network Schedule	\$31 \$51 \$64 \$80
Contact Lenses <ul style="list-style-type: none"> <li>• Medically Necessary, with Prior Authorization</li> <li>• Elective</li> </ul>	12 Months	None	Network Schedule  \$150	\$210  \$150
ProTec Safety Glasses, prescription lenses only, with frames, Active Members only	24 Months	\$25	Network Schedule	\$0

\*Subject to additional limitations set forth below.

The frequency limitation is the number of months that must elapse after a listed service or supply is furnished to a Covered Person before the same service or supply will again be covered for the same Covered Person.

A Copayment is the amount a Covered Person must pay the Provider at the time a listed service or supply is obtained from an In-Network (VSP) Provider. Non-Network Providers require full payment at the time of service.

## C. Covered Vision Services and Supplies

The only services and supplies for which the Plan pays vision benefits are those listed in the table set forth in Subsection B.2 above.

Listed services and supplies are covered for benefits only if they:

1. Are performed or furnished by a licensed optometrist, ophthalmologist, or dispensing optician;
2. Conform to the additional conditions and limitations set forth in Subsection D below; and
3. Are not excluded under the general exclusions set forth in Subsection G below.

## D. Additional Conditions and Limitations

### 1. Eye Examinations

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

For purposes of the VSP Provider maximum benefit, the Network scheduled amount is the amount the Provider has agreed to accept, as a Member of the Network, for standard eye examinations as defined by VSP.

### 2. Eyeglass Lenses and Frames

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

For purposes of the VSP Provider maximum benefit for lenses, the Network scheduled amount is the amount the Provider has agreed to accept, as a Member of the Network, for standard lenses as defined by VSP. If a Covered Person elects to obtain non-standard lenses from a VSP Provider, including but not limited to those with any of the following features, the Covered Person will be required to pay the extra cost over the scheduled amount for standard lenses:

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

For purposes of the VSP Provider maximum benefit for frames, the Network scheduled amount is the amount the Provider has agreed to accept, as a Member of the Network, for standard frames as defined by VSP. If a Covered Person elects to obtain non-standard frames from a VSP Provider, the Covered Person will be required to pay the extra cost over the scheduled amount for standard frames.

Lenses and frames obtained from a VSP Provider include the following professional services:

- a. Prescribing and ordering proper lenses;
- b. Assisting in the selection of frames;
- c. Verifying the accuracy of the finished lenses;
- d. Fitting and adjustment of frames;
- e. Subsequent adjustments to frames to maintain comfort and efficiency; and
- f. Progress or follow-up work as necessary.

Any charges by a Non-Network Provider for such services are included in the amount subject to the Plan's maximum benefit for lenses and frames.

### 3. Contact Lenses

Contact lenses are covered, subject to the applicable frequency limitation, 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 a Non-Network Provider for such services are included in the amount subject to the Plan's maximum benefit for contact lenses.

For purposes of the VSP Provider maximum benefit for Medically Necessary contact lenses, the Network scheduled amount is the amount the Provider has agreed to accept, as a Member of the Network, for standard contact lenses as defined by VSP. Contacts will be considered Medically Necessary only in one or more of the following situations, and only if pre-authorized by VSP:

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

Plan benefits at the Medically Necessary level are not payable unless Prior Authorization was obtained before commencement of services, confirming the Medical Necessity of contact lenses instead of eyeglasses. The Plan contracts for VSP to furnish Prior Authorization advice for the Vision Benefit. A Covered Person is responsible for ensuring that required Prior Authorization is obtained for services of a Non-Network Provider. Requests for Prior Authorization must be submitted to VSP. The procedures set forth in sections II.D.2 and II.D.3 above will apply. Prior Authorization alone does not guarantee either coverage, or availability of benefits.

#### **E. Additional Discount**

Each Member and Dependent is entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP Network Provider. Additional pair means any complete pair of prescription glasses that is not covered under this Plan.

Additionally, Members and Dependents are entitled to receive a discount of fifteen percent (15%) off a VSP Network Provider's professional fees for contact lens evaluations and fittings that are not covered under this Plan. Discounts are applied to the VSP Network Provider's usual and customary fees for such services and are available from a VSP Network Provider who provides a covered eye examination, for services provided within twelve (12) months after the covered eye examination. This discount does not apply to contact lens materials, which are provided at the doctor's usual and customary charges.

#### **F. 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 a Non-Network Provider, the Plan will pay the lesser of the billed charge or the maximum benefit amount set forth in Subsection B.2 above, in either case reduced by any required Copayment. In all cases, however, the Plan benefit payable is also subject to the additional conditions and limitations of Subsection D above, and the exclusions set forth in Subsection G.

A Covered Person must pay in full the amount due a Non-Network Provider for covered services and supplies, and file a claim with VSP for reimbursement from Plan benefits.

There are no deductibles, Coinsurance rates or Out-of-Pocket limits applicable to the Vision Benefit. The Covered Person is responsible for the portion of a billed charge in excess of the Plan benefits payable. In-Network Providers may not bill an amount in excess of the uniform charge the Provider has agreed to accept as a Member of the Network; whereas Non-Network Providers are not limited in the amount they may charge.

## **G. General Exclusions**

Irrespective of all other provisions, no vision benefits will be paid for or in connection with

1. Optional cosmetic features such as anti-reflective coating, color coating, mirror coating or scratch coating, blended lenses, cosmetic lenses, laminated lenses oversize lenses, progressive multifocal lenses, UV (ultraviolet) protected lenses, and photochromic lenses; tinted lenses except Pink #1 and Pink #2.
2. Orthoptics or vision training, and any associated supplemental testing; Plano lenses (less than a  $\pm.38$  diopter power); or a second pair of glasses in lieu of bifocals.
3. Replacement of lenses and frames furnished under this Plan which are lost or broken, except in compliance with the frequency limitation in Subsection B.2 above.
4. Medical or surgical treatment of the eyes.
5. Any eye examination or corrective eyewear, not otherwise covered by the Plan, required by an Employer as a condition of employment.
6. Experimental or Investigative services or supplies
7. Drugs or medications.
8. Corrective vision treatments such as RK, PRK LASIK and Custom LASIK.
9. Care, services or supplies received as a result of any Injury or Sickness sustained due to the act or omission of a third party, unless the Covered Individual has fully complied with the reimbursement or subrogation provisions of this Plan.
10. Any vision services to the extent that benefits are payable under the Medical Benefit of this Plan.
11. Costs for services and supplies in excess of Plan maximum benefits.

## **H. Special Low Vision Benefit**

Independent of, and in addition to, the benefits described in Subsections B through F above, the Plan offers a special low vision benefit program through VSP, under eligibility criteria established by VSP.

If an eye examination performed by a VSP Provider or Non-VSP Provider indicates that a Covered Person has a severe visual problem that is not correctable with regular lenses, the Covered Person or Provider may submit a request to VSP for approval of coverage in the low vision program. Requests for pre-approval of low vision benefits must be directed to VSP Member Services at (800) 877-7195 or on the VSP web site at [www.vsp.com](http://www.vsp.com). If the request is approved as appropriate to the particular patient under VSP criteria, the patient may obtain a complete low vision analysis that includes a comprehensive exam of visual functions and prescription of corrective eyewear or vision aids if indicated. If a VSP Provider performs the low vision analysis, a \$10 Copayment applies and the remainder is paid in full by the Plan. If a Non-VSP Provider performs the low vision analysis, the Plan benefit is the lesser of the amount charged or \$125.

If the low vision analysis includes a prescription for additional therapy, corrective eyewear or vision aids, the Plan will pay an additional benefit for the prescribed items at a Coinsurance rate of 75% of the lesser of the charged amount or the amount authorized by VSP, regardless whether furnished by a VSP Provider or a Non-VSP Provider. The balance of the Provider's charge must be paid by the Covered Person.

The maximum aggregate benefit amount payable by the Plan under the special low vision benefit is \$1,000 on account of all Covered Charges incurred during each successive period of 24 months, beginning when the first such Covered Charge is incurred.

## **I. 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 a Non-Network Provider is responsible for filing a timely claim for reimbursement with VSP.

## Section VII

### Short Term Disability Benefits

The Plan provides an ancillary benefit to assist Members who are unable to work during periods of temporary disability.

#### A. Eligibility for Short Term Disability Benefits

A Member in the Active Classification who becomes temporarily disabled because of a non-occupational accident or Sickness that occurs while eligible for medical benefits in the Plan is eligible to receive benefits under the terms and conditions stated below. For this purpose, “disabled” means that the Member is prevented, due solely to the Sickness or Injury, from engaging in gainful employment. In addition:

1. The Member must be under the direct care and attendance of a Physician, who certifies that the Member is disabled within the foregoing definition and states an expected return to work date.
2. The treating Physician must notify the Plan of any changes to the expected return to work date. In addition, the Provider may be required to submit documentation for support of continued disability determinations at any time upon the Plan’s request.
3. For disability caused by an accident, the Member must provide the Plan with complete details of time, place and circumstances of the accident.

#### B. Benefits Payable

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

BENEFIT	AMOUNT
Short Term Disability (Weekly Indemnity)	\$300 per week

Benefits begin on the first day of an accident disability, Hospital confinement or outpatient surgery or for a Sickness without Hospital confinement or outpatient surgery, on the eighth day after the disability onset date certified by the Member’s Physician. 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. Benefits will be paid for no more than 26 weeks during a period of disability.

Successive periods of disability, separated by less than 80 Credit Hours of work in Covered Employment, will be considered as one period of disability, unless the subsequent disability is due to an Injury or Sickness entirely unrelated to the cause of the previous disability and the two disabilities are separated by at least eight Credit Hours of work in Covered Employment. Hours received and paid for as a result of picket duty do not qualify as Credit Hours for this purpose. Benefits terminate on the last day of the Member’s disability or, if earlier, after a maximum of 26 weeks of disability benefits have been paid.

The Plan will deduct from Short Term Disability benefits the amount of required FICA contributions, and will issue to the Member an annual Form W-2 form reporting the amount paid under this benefit for the calendar year.

#### C. Exclusions

No benefits are payable under this Section VII:

1. For any day of disability on which a Member is eligible for, or receiving, compensation from the Member’s employer, or Worker’s Compensation benefits, even if occupational and non-occupational disabilities are unrelated.

2. For 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.
3. For periods that exceed accepted standards of disability, unless properly documented by the treating Physician.
4. For any day prior to or after the period when a Member was under treatment, and was certified as disabled, by an attending Physician, even though the Sickness or illness may have been present.
5. For any day on which the Trustees determine that a Member was not disabled, though certified as such by a Physician.
6. For disability resulting from any Injury or Sickness for which no medical benefits are payable.
7. For any member while covered under COBRA.

## Section VIII

### Life Insurance and Safety Enhancement Benefits

#### A. Life Insurance Benefits

The Plan provides Life and Accidental Death and Dismemberment (AD&D) benefits under policies insured by a commercial insurance company. The terms and conditions of such benefits are as stated in the policies, which are adopted and incorporated by reference. The coverages are summarized in this Section VIII, but in case of any conflict or inconsistency, the terms of the policies will prevail. A copy of the certificate containing policy terms may be examined at the 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. The insurance carrier at the date of this restated Plan Document is Metropolitan Life Insurance Company (MetLife).

##### 1. Eligibility for Life and AD&D Benefits

A Member of any classification is eligible for Life insurance and AD&D benefits so long as the Member is eligible for medical benefits in the Plan, or is enrolled in the UHC Medicare Advantage Program, except for a Member in the Non-Active Classification who is covered under the reinstatement provisions of this Plan.

A Dependent who dies while eligible for medical benefits in the Plan, or is enrolled in the UHC Medicare Advantage Program, is eligible for Life insurance, but not AD&D benefits, except for the following Dependents, who are not eligible for either Life insurance or AD&D benefits:

- a. An individual who lived outside the United States or Canada at the time of death;
- b. A stillborn or unborn child;
- c. An individual in whom the insurance company determines that the related Member had no insurable interest; or
- d. 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.

##### 2. Level of Death Benefits

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

BENEFIT	AMOUNT
Insurance on Life of Member	\$8,000
Insurance on Life of eligible Dependent	\$2,000
AD&D death benefit (Members only)	\$8,000

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. When payable under the terms of the AD&D policy, the AD&D death benefit is payable in addition to the Life insurance benefit. Under no circumstances will an amount greater than the applicable amount shown in the foregoing table be paid as benefits of this Plan on account of the death of a Member or Dependent, except for interest that may become payable after death under the terms of the policy.

### **3. Death Beneficiary**

The proceeds payable under the Life insurance and AD&D policies as benefits on account of the death of a Member will be paid to the Member's designated beneficiary.

A designated beneficiary is a person the Member designates in writing on the Plan's form filed in the Plan office. If more than one beneficiary is named, the proceeds will be distributed equally to them unless the Member has directed otherwise on the designation form. If any designated beneficiary predeceases the Member, that beneficiary's interest terminates and the proceeds will be paid to the surviving designated beneficiaries. If the most recent beneficiary designation form filed at the Plan office at the time of death names a Member's former spouse who was divorced or whose marriage was annulled after the form was filed, the death benefit will be paid as if the former spouse had predeceased the Member.

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 for a Member will be paid as follows:

- a. To the Member's surviving spouse.
- b. If there is no surviving spouse, to the Member's surviving child or children, equally.
- c. If there are no surviving children, to the Member's surviving parents, equally.
- d. If there are no surviving parents, to the Member's siblings, equally.
- e. If there are no surviving siblings, to the Member's estate.

A Member may designate or change a beneficiary at any time by signing and dating a new designation form. Any designation or change will become effective upon the Plan's receipt of the signed and dated form, and will relate back and take effect as of the date the Member signed the form, whether or not the Member is living at the time of receipt of the request, but without prejudice to the Plan or insurance company on account of any payment made before receipt of such written notice.

Information concerning beneficiary designations will be furnished only to the Member or, after the Member's death, to the Member's personal representative or the designated beneficiary when properly identified.

The proceeds payable under the Life insurance policy as benefits on account of the death of a Dependent will be paid to the related 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.

### **4. Extended Life Insurance (Members Only)**

If a Member becomes totally disabled before age 60 while eligible for Life insurance benefits and if the Member's eligibility for Life insurance benefits would otherwise end, the Life insurance benefit in effect on the date eligibility would otherwise end will nevertheless be paid at the Member's death, provided the Member:

- a. Remains continuously totally disabled,
- b. Submits written proof of the uninterrupted continuance of Total Disability to the insurance company as follows:
  - a. The first such proof must be received within 12 months after the date the Member ceases Active Work. If the Member dies during this 12-month period, the insurance company must receive proof not more than 12 months after the date of death.
  - b. Thereafter, whenever the insurance company requests proof of continuing Total Disability.
  - c. Submits to medical examination by a Physician selected by the insurance company whenever required by the insurance company,
  - d. Does not establish a claim under the conversion privilege, and
  - e. Surrenders to the insurance company any policy of personal insurance issued on the Member's life pursuant to the conversion privilege provision. The insurance company will refund Premiums paid less any dividends or other indebtedness.

For purposes of this benefit, “totally disabled” means 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.

**5. Life Insurance Conversion Privilege (Members and Dependents)**

If a Member’s or Dependent’s Life insurance coverage under the Plan ends because of termination of eligibility, such Covered Person has the right to convert to an individual policy of life insurance as described in Certificate of Coverage by making application to the insurance company.

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

**B. Dismemberment Benefits**

**1. Level of Benefits**

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

FOR LOSS OF:	THE AD&D BENEFIT IS:
Life	100%
One hand, one foot or the sight of one eye	50%
Both hands, both feet, sight of both eyes or any combination of two or more of the above losses	100%

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

**2. Limitations on AD&D Benefits**

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

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

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

**C. Safety Enhancement Benefits**

**1. Eligibility**

The persons eligible for safety enhancement benefits under this Section VIII are:

- a. All employees covered by a collective bargaining agreement between an Employer and the Carpenters' District Council of Greater St. Louis and Vicinity (CDC);
- b. Employees of the CDC; and
- c. Employees of the Carpenters' Benefit Fund Office.

Safety enhancement benefits are available regardless of whether such employees have earned eligibility for medical benefits under Section I.

## 2. Safety Training

The Plan will provide without charge, to all persons eligible under this Subsection C, the Safety Training course known as the “10-Hour OSHA Course.”

Upon completion of the 10-Hour OSHA course, the Plan will provide without charge to all active Members 8 Hours of Approved Safety Training per year 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. Member Training records may also be accessed from the website after logging in to the Member's account at [www.carpdc.org](http://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 Ext 1044, or Toll-Free at 877.232.3863, Ext 1044. In addition, courses and school links can be found from the Home Page of [www.carpdc.org](http://www.carpdc.org) under the Skill Advancement menu.

## 3. Substance Abuse Testing

The Plan will provide without charge, to all persons eligible under this Subsection C, and to employees of the Carpenters’ Joint Apprenticeship Fund of St. Louis, testing for the presence in blood or urine of alcohol or controlled substances under the procedures approved or modified from time to time by the Trustees.

The objective of this Drug and Alcohol Testing Program is to improve safety, productivity and morale on all construction sites and to eliminate duplicate and redundant testing for its 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:

**PCS Drug Screening, LLC – Cape Office**  
 21 Doctors’ Park, Cape Girardeau, MO 63703  
 Toll Free: 800.329.2660  
 Phone: 573.334.4788  
 Fax: 573.332.1593  
 Hours: M – F, 8:30am-4:30pm

**PCS Drug Screening, LLC – St. Louis**  
 8300 Valcour Ave, St Louis, MO 63123  
 Phone: 314.752.1100  
 Fax: 314.752.4100  
 Hours: M, W, Th, F, 7am-4pm; Tu 7am- 6pm

**PCS Drug Screening, LLC – Belleville**  
 Southern Illinois Training School  
 2290 South Illinois St, Belleville, IL 62220  
 Phone: 618.222.9880  
 Fax: 618.222.9883  
 Hrs: M 7am-4pm; Tu 1pm-5pm; Wed-Fri  
 12pm-4pm

**PCS Drug Screening, LLC – Kansas City**  
 Kansas City District Council  
 105 W 12<sup>th</sup> Ave, North Kansas City, MO 64116  
 Phone: 816.756.1300  
 Fax: 816.756.1304  
 Hours: Mon-Fri 8am-4pm

Additional information is available in the Drug Testing and Safety Training Policy and Procedure document available at the Plan Office.

## Section IX

### Claims and Appeals Procedure

#### A. Generally

A claim is a request for benefits under the Plan made by or on behalf of a Covered Person who has received covered services or supplies (a “Claimant”). A claim will be determined initially by the Plan’s representatives. A Claimant who is dissatisfied with the initial claim determination may file an internal Appeal, which will be decided by 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 IX, an “Adverse Benefit Determination” is a denial, reduction or termination of, or failure to provide or make payment for, a benefit, or any rescission of coverage within the meaning of 45 CFR §147.128, whether or not based on a determination of eligibility or application of any utilization review, including failure to cover a service or supply for which benefits are otherwise provided because it is experimental, investigative or not Medically Necessary. A “final internal Adverse Benefit Determination” is an Adverse Benefit Determination 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 within the meaning of 29 CFR §2560.503-1.

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

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

#### B. Filing A Claim

##### 1. Medical Benefits

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

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  
PO Box 7796  
London, KY 40742

##### 2. Prescription Drug Benefits

The Plan has contracted with Express Scripts to process claims for the Prescription Drug Benefit, to make Prior Authorization determinations, and for access to the drug Networks. Therefore, all claims for prescription drug benefits must be submitted directly to Express Scripts, regardless 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/](http://www.carpdc.org/BenefitServices/Forms/) or by calling the Benefit Office and requesting an Express Scripts' claim form.

### **3. Vision Benefits**

Claims for vision benefits must be filed with the Plan's Network Sponsor, Vision Service Plan (VSP). If a Claimant obtains services or supplies from an In-Network Provider, and has paid any applicable Copayment and furnished the Provider with the Plan's Vision ID card, a claim will be filed directly by the Provider. It is the responsibility of an In-Network Provider to file accurate and timely claims with the Plan, and if an In-Network Provider fails to do so, the Claimant will not be liable to the Provider for the Plan benefits that would have been payable. If services or supplies are obtained from a Non-Network Provider, it is the responsibility of the Claimant to see that an accurate and timely claim is filed, by the Provider or Claimant. If a Claimant pays a Provider directly, the Claimant may file a claim for reimbursement of any Plan benefits that were due but not paid to the Provider by the Plan. A claim for such reimbursement must be submitted to VSP on a VSP claim form, which can be obtained at [www.carpdc.org/BenefitServices/Forms/](http://www.carpdc.org/BenefitServices/Forms/) or by calling the Benefit Office and requesting a VSP claim form.

### **4. Dental Benefits**

The Plan has contracted with Delta Dental, LLP to process dental claims, and for access to the Dental Network. Therefore, all claims for dental benefits must be submitted directly to Delta Dental, regardless whether from In-Network or Non-Network Providers. A claim for dental benefits should be filed within 90 days after services are rendered.

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

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

## **5. Life Insurance and Accidental Death and Dismemberment Benefit**

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

## **6. Short Term Disability Benefit and Other Disability Determinations**

A claim under the Short Term Disability 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, Missouri 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 Short Term Disability 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 Short Term Disability claims shall govern to the extent applicable.

## **C. Notification of Initial Benefit Determination**

### **1. Urgent Care Claims**

For purposes of these procedures, an "urgent care claim" is a claim for benefits for medical care or treatment with respect to 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

- a. the Plan's receipt of the specified additional information, or
- b. the end of the period afforded the Claimant to provide the specified additional information.

### **2. Concurrent Care Claims**

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

Any request by a Claimant to extend a previously approved course of Urgent Care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided 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.

### **3. Pre-Service Claims**

For purposes of these procedures, a “pre-service claim” is a claim that is not an urgent care claim or concurrent care claim, for benefits for a service or supply for which the Plan requires Prior Authorization as a condition of receiving some or all benefits. If the Claimant fails to follow these procedures for filing the claim, the Plan will notify the Claimant as soon as possible, but not later than 5 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, notice of extension shall specifically describe the required information, and the Claimant will be afforded 45 days from receipt of the notice to provide the specified information.

### **4. Post-Service Claims**

For purposes of these procedures, a “post-service claim” is a healthcare claim that is neither an urgent care claim nor a concurrent care claim nor a pre-service claim. The Plan will notify the Claimant of the Plan's Adverse Benefit Determination of a compliant post-service claim within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to matters beyond the control of the Plan, additional time is needed to process a claim, the Plan may extend the time for notifying the Claimant of the Plan's benefit determination 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.

### **5. 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.

### **6. 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 3 days by written or electronic communication. Electronic communication shall comply with requirements of 29 CFR §2520.104b-1(c)(1)(i), (iii), and (iv).

A notification of initial Adverse Benefit Determination shall identify the claim by date of service, Provider and claim amount. The notification shall include:

- a. The specific reason or reasons for the adverse determination;

- b. Reference to the specific Plan provision on which the determination is based;
- c. A description of any additional material or information necessary for the Claimant to perfect the claim with an explanation of why such material is necessary;
- d. A statement that the Claimant may receive on request the diagnosis code, the denial code, an explanation of the meaning of such codes;
- e. A description of available internal Appeals and external review processes, with information regarding how to initiate an Appeal; and
- f. A statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review.

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.

## **D. 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.

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

A Claimant has one hundred eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to request an Appeal 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, Missouri 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, within the meaning of 29 CFR §2560.503-1, 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.

## **2. 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.

## **3. Notification of Decision on Appeal**

### **a. Urgent Care Claims**

The Plan or its agent shall notify the Claimant of the Plan's decision on Appeal of an urgent claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for Appeal of the initial Adverse Benefit Determination by the Plan.

### **b. Pre-service or Concurrent Care Claims**

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.

### **c. Post-service and Disability Claims**

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 (5) days after the benefit determination is made.

**d. 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.

**e. Manner and Content of Notice of Decision on Appeal**

The Plan will provide notice of an Adverse Benefit Determination to the Claimant in writing or by electronic communication. Electronic communication shall comply with requirements of 29 CFR §2520.104b-1(c)(1)(i), (iii), and (iv).

A notification of final Adverse Benefit Determination shall identify the claim by date of service, Provider and claim amount, and shall include:

- 1) The specific reason or reasons for the adverse determination, with discussion of the decision;
- 2) Reference to the specific Plan provision on which the determination is based;
- 3) A statement that the Claimant is entitled to receive, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant, within the meaning of 29 CFR §2560.503-1, to the Claimant's claim for benefits;
- 4) A statement that the Claimant may receive on request the diagnosis code, the denial code, an explanation of the meaning of such codes;
- 5) A description of available external review processes, with information regarding how to initiate an external review; and
- 6) A statement of the Claimant's right to bring a civil action under section 502(a) of ERISA, with the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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 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.

**E. 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 Plan 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.

## **F. 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 following procedure:

### **1. Standard External Review Process**

Standard external review is external review that is not considered expedited (as described in paragraph F.2. below).

- a. A Claimant may file a request for external review within four months after receipt of a notice that a claim or internal Appeal was denied. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.
- b. Within five business days after receipt of a request for external review, the Plan will complete a preliminary review to verify that the Claimant was covered by the Plan at the time the service or supply in question was provided, that the claim or Appeal denial was not based on ineligibility for coverage, that the Claimant has exhausted the Plan’s internal claims and Appeals processes (or is deemed under applicable regulations to have done so), that the claim or Appeal denial is otherwise eligible for external review, and that the Claimant has furnished all information required to process an external review.
- c. The Plan will notify the Claimant in writing of whether the request is complete and the request is eligible for external review within one business day after completion of the preliminary review. If the request is not eligible for external review, the notice will explain why, and provide contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information needed, and the Plan will allow the Claimant to perfect the request within the four-month filing period or, if longer, within 48 hours after receipt of the notice.
- d. The Plan will contract with at least three accredited Independent Review Organizations (IROs), and will assign eligible requests for external review to them in rotating order.
- e. Within five business days after assignment of a request to an IRO, the Plan will provide to the IRO the documents and information considered by the Plan in denying the claim or Appeal.
- f. Regulations provide that the IRO will (1) notify the Claimant of the request’s eligibility and acceptance for review and allow the Claimant ten days to submit additional information for consideration; (2) forward any additional information submitted by the Claimant to the Plan; (3) review the claim without consideration for the previous decisions made by the Plan; and (4) provide written notice to the Plan and the Claimant of the IRO’s final decision within 45 days after receiving the request for external review. The decision notice will contain the receipt date of the review, a detailed description of the evidence or documentation considered, the principal reasons for the decision, a notification of the remedies available to either party under federal law, including judicial review available to the Claimant, and contact information for health insurance consumer assistance ombudsman established under the Public Health Services Act.

## **2. Expedited External Review**

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

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

## Section X

### Multiple Coverage Limitations

#### A. Coordination of Benefits with other Medical Plans

The medical, prescription drug, dental and vision benefits of this Plan are subject to coordination of benefits (COB). If a Covered Person is eligible to receive such benefits under both this Plan and one or more other plans, including no-fault automobile insurance, benefits will be coordinated so that the total amount paid by all plans will not exceed 100% of the Allowable Expenses incurred.

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

Any COB questions not addressed by the express language of this Plan will be determined in accordance with the guidelines promulgated by the National Association of Insurance Commissioner (NAIC).

#### B. Purpose

The purpose of COB is to:

1. Establish a uniform order of benefit determination under which plans pay claims;
2. Avoid duplication of benefits by reducing benefits to be paid by plans that do not have to pay their benefits first; and
3. Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

#### C. Definitions

The following terms, whether or not capitalized, shall have the meanings indicated:

1. A **“plan”** with which this Plan coordinates benefits is any arrangement that provides benefits or services for medical, prescription drug, vision or dental care or treatment, including any of the types of coverage, plans or programs listed below or any other contractual arrangements under which such benefits for an individual and his dependents can be obtained and maintained.
  - a. Any group or non-group insurance, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured) ; medical care components of long term care contracts, such as skilled nursing care; and Medicare or any other federal or state governmental plan, as permitted by law.
  - b. Any self-insured or non-insured plan, or any other plan, arranged through any Employer, trustee, Union, Employer organization, or employee benefit organization.
  - c. Any Hospital service pre-payment plan, medical service pre-payment plan, group practice and any other pre-payment coverage.
  - d. Any coverage for students that is sponsored by, or provided through a school or other educational institution.
  - e. The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts;

The term "plan" shall not include Hospital indemnity-type contracts, or a state plan under Medicaid.

The term “plan” shall not be applied separately to separate parts of a single plan that are intended to be part of a coordinated package of benefits. However, the term "plan" shall be applied separately to each program, policy, contract or other arrangement for benefits or services, or portion thereof, which itself constitutes a “plan.” The term “plan” shall also be applied separately to that portion of each program,

policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits and that portion which does not.

2. **“Allowable expense”** is a health care expense, including deductibles, Coinsurance and Copayments, that is covered at least in part by this Plan or another plan with which benefits are coordinated. For benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense. An expense that is not covered by any plan coordinating benefits is not an Allowable Expense. Any expense that a Provider is prohibited by law or a contractual obligation from charging a Covered Person is not an Allowable Expense. The following are examples of expenses that are and are not Allowable Expenses:
  - a. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the plans provides coverage for private Hospital room expenses.
  - b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
  - c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  - d. If a person is covered by a primary plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, and by a secondary plan that provides its benefits or services on the basis of negotiated fees, and if the Provider’s contract permits, the negotiated fee shall be the Allowable Expense used by the secondary plan to determine its benefits.
  - e. The amount of any benefit reduction by the primary plan because the Covered Person has failed to comply with plan provisions such as second surgical opinions, Prior Authorization or precertification of admissions, or preferred Provider arrangements, is not an Allowable Expense.
  - f. Health care expenses covered for dissimilar benefits are not Allowable Expenses. For example, in coordinating this Plan’s medical benefit, an expense covered in another plan’s dental benefit will not be considered an Allowable Expense, nor will an expense covered in another plan’s medical benefit for a service or supply excluded in this Plan be considered an Allowable Expense.
3. **“Birthday”** refers only to the month and day of a person’s birth and does not include the year in which the person was born.
4. **“Claim”** means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of services or supplies, or payment for services or supplies, or a combination.
5. **“Closed panel plan”** is a plan that provides health care benefits primarily in the form of services furnished through a panel of Providers that have contracted with or are employed by the plan, and that excludes coverage for services furnished by other Providers, except in cases of Emergency or referral by a panel Member.
6. **“COBRA coverage”** means continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.
7. **“Coordination of Benefits”** or **“COB”** means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable expenses.
8. **“Custodial parent”** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitations.
9. **“Group-type contract”** means a contract that is not available to the general public and is obtained and maintained only because of Membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued policy.

10. “**High deductible health plan**” has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

#### **D. Rules for Determining Primary Plan**

When a person is covered by two or more plans, the rules for determining which plan is primary are as follows:

1. Except as provided in paragraph (2) below, a plan that does not contain a coordination of benefits provision that is consistent with this Plan’s provision is always primary, unless the provisions of both plans state that this Plan is primary.
2. A plan with coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a benefit package and provides that this supplementary coverage shall be excess to any other parts of this Plan is always secondary. Examples of these types of plans are coverages that are primarily used to provide protection from excluded benefits or services over the maximum allowed under this Plan.
3. If another plan provides benefits on an excess insurance or excess coverage basis, the plan will always be primary to this Plan.
4. If paragraphs 1, 2 and 3 do not apply, each plan determines its order of benefits using the first of the following rules that apply:
  - a. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, Member, policyholder, subscriber or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary, and if, under federal law, Medicare is secondary to the plan covering the person as a dependent, then the order of benefits between the two plans is reversed so that the plan the plan covering the person as a dependent is primary and Medicare is secondary.
  - b. **Dependent Child Covered Under More than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
    - 1) For a dependent child whose parents are married or are living together, whether or not they have ever been married,
      - a) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      - b) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
    - 2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married,
      - a) If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage, that plan is primary commencing in the first full Plan Year after this Plan is given notice of the court decree;
      - b) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of subparagraph 4.b.1 above shall determine the order of benefits;
      - c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph 4.b.1 above shall determine the order of benefits; or
      - d) If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child is as follows:
        - i. The plan covering the Custodial parent;
        - ii. The plan covering the spouse of the Custodial parent;

- iii. The plan covering the non-custodial parent;
- iv. The plan covering the spouse of the non-custodial parent.
- e) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph 4.b.1 or 4.b.2 above shall determine the order of benefits as if those individuals were the parents of the child.
- f) For a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under his or her own spouse's plan, the rule of longer or shorter coverage applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's spouse.
- g) For a dependent step-child, this Plan will always be the secondary plan.
- c. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as a currently working active employee, that is, an employee who is neither laid off nor retired, is the primary plan for the employee and dependents. The plan covering that same person as a retired or laid-off employee is the secondary plan for the employee and dependents. However, this subparagraph c. is disregarded if the other plan does not have the same rule, or if the rule in subparagraph D.3.a. (Non-Dependent or Dependent) can determine the order of benefits.
- d. **COBRA or Other Continuation Coverage.** A plan that covers a person under COBRA or other continuation coverage required by law is secondary to a plan that covers the person without continuation coverage as an employee, Member subscriber or retiree or as a dependent of an employee, Member, subscriber or retiree. However, this subparagraph d. is disregarded if the other plan does not have the same rule, or if the rule in subparagraph D.3.a. (Non-Dependent or Dependent) can determine the order of benefits.
- e. **Longer or Shorter Length of Coverage.** The plan that 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. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the Covered Person became covered under the second plan within twenty-four (24) hours after coverage under the first plan ended.
- f. If the preceding rules do not determine the order of benefits, Allowable Expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

## E. Effect of COB on the Benefits of this Plan

When this Plan coordinates benefits with another plan, either plan may be determined to be primary under the foregoing rules. A plan may consider the benefits paid or provided by another plan in calculating the benefits it will pay only when it is secondary to that other plan. The primary plan will pay benefits as if it were the only plan, without consideration of any secondary plan.

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage, and apply that calculated amount to any Allowable Expense under its plan that is unpaid 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 all plans do not exceed the total Allowable Expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

1. If a Covered Person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan; benefits will not be coordinated between that plan and the other closed panel plans.

2. When this Plan is secondary in coordinating benefits with a primary plan, the claim for benefits from this Plan must be filed within one year from the date the Covered Charges are incurred. The claim must include a copy of the explanation of benefits issued by the primary plan, as well as a copy of the Provider's itemized bill. The filing deadline is not extended on account of delay in processing by the primary plan, or on account of later related claims.
3. If 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.

#### **F. Coordination with Medicare - Active Members and Dependents**

This Plan will be primary to Medicare for Members in the Active Classification, and their Dependents, who qualify for Medicare due to age, with the following exceptions: The Plan will be secondary to Medicare for a Member in the Active Classification, and a Dependent of such Member, who works for a "small Employer" within the meaning of the Medicare regulations. The Plan will also be secondary to Medicare for a 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.

#### **G. Right to Receive and Release Needed Information**

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

#### **H. Payment Adjustments**

If benefit payments that should have been made by this Plan in accordance with this Section X have instead been made by any other plan, the Trustees have the right, exercisable alone and in their sole discretion, to pay over to the plan making such payments any amounts they determine to be warranted in order to satisfy the intent of this Section X, and amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payments, the Trustees will be fully discharged from liability under this Plan.

#### **I. Right of Recovery**

If benefit payments have been made by this Plan with respect to Allowable Expenses in excess of the total amount of payment necessary at the time to comply with this Section X, the Trustees have the right to recover such excess from one or more of the persons it has paid, or from the Covered Person for whom such benefits were paid; or any other person or organization that may be responsible for the benefits or services provided to the Covered Person. Such payment shall be returned in a lump sum or deducted from future covered claims. The amount of benefit payments made includes the reasonable cash value of any benefits provided in the form of services.

## **Section XI**

### **Third Party Liability – Subrogation and Reimbursement**

#### **A. Generally**

1. 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 XI.
2. If the Trustees determine, in their discretion, that there is a reasonable likelihood that a third party is liable to make payment to a Covered Person for an Injury or illness, the Trustees may withhold benefits from the Covered Person for the Injury or illness until the liability of the third party is finally determined. In their discretion, the Trustees may instead advance benefits to the Covered Person who sustained the Injury or Sickness, subject to the subrogation and reimbursement provisions of the Plan.
3. The Plan shall advance benefits for Covered Expenses related to such illness or Injury only to the extent not paid by the third party and only after the Covered Person and his or her attorney, (as applicable) have entered into the Plan's written subrogation and reimbursement agreement in its entirety. If the Covered Person and/or the attorney (as applicable) fails to sign and deliver an agreement requested by the Plan, the Trustees may decline to advance any benefits before the liability of the third party has been determined.
4. A Covered Person's own automobile insurance carrier is deemed a third party with respect to uninsured or underinsured coverage.
5. Any payment made by a third party on account of an Injury or Sickness covered by the Plan is referred to herein as a "third-party recovery."
6. A Covered Person is not required to accept an advance of benefits in case of an Injury or 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.

#### **B. Subrogation**

1. In any instance in which benefits are advanced or otherwise paid by the Plan on account of a Covered Person's Injury or 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.
2. The Plan, after giving notice to the Covered Person and his or her attorney (as applicable), may (but is not obligated to) institute and prosecute any legal action in the name and on behalf of the Covered Person against any potentially liable third party, and if a recovery is had, the Plan shall be entitled to receive and retain therefrom the amount of benefits paid and all costs, expenses and attorney's fees incurred in obtaining such recovery, and shall pay over any excess to the Covered Person. The Trustees shall have the right in their discretion to compromise and settle the amount of any such claim pursued directly by the Plan on behalf of a Covered Person.
3. The Plan, as subrogee of a Covered Person, shall have the right to 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.

#### **C. Reimbursement Obligation**

1. In the event that a Covered Person shall recover any amount from a third party, by judgment, settlement or otherwise, for an act or omission causing (in whole or in part) an Injury or 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:
  - a. The amount of the Covered Person's reimbursement obligation is the full amount (100%) of benefits paid by the Plan for such Injury or 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.

- b. 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.
- c. The Covered Person's reimbursement obligation shall be secured by a first lien in favor of the Plan on the gross third-party recovery, prior to all other claims or liens including those for attorney's fees. The Covered Person shall have no right or power to defeat or diminish the Plan's lien by committing all or part of a third-party recovery to another person or entity. The Plan may notify the third party, his or her insurer, his or her attorney, or anyone else of the Plan's lien and other rights with respect to a third-party recovery.
- d. The third-party recovery, to the extent of the Plan's interest therein, is a plan asset and the Covered Person and his or her attorney and anyone else in possession of the third-party recovery shall hold the same In Trust, 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.
- e. The Covered Person's reimbursement obligation is a debt owed by the Covered Person to the Plan, independent of the third-party recovery Fund. If for any reason the reimbursement obligation is not promptly paid in full 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.
- f. A Member is responsible for performing all obligations of a Covered Person who is the Member's eligible spouse or other eligible Dependent.
- g. 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.
- h. If a Covered Person receives a third-party recovery in excess of benefits paid out at that time, and reimburses the Plan for all such benefits paid, 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.
- i. If a Covered Person receives a third-party recovery that is less than benefits paid to that time, the plan may require an uninsured or underinsured motorist claim to be filed against the Covered Person's automobile insurance policy in order to satisfy the balance of the Covered Person's reimbursement obligation.

#### **D. Duty to Cooperate with the Plan**

1. 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.
2. 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.

3. 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.
4. 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.
5. 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.
6. 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 XI, the Plan is released from its obligation to pay benefits to the extent of the refused offer.
7. In the event that the Plan has declined to advance benefits under the provisions of this Section XI 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 XI, and it is established to the satisfaction of the Trustees, in the exercise of their discretion, that no third-party recovery can be had, or that a third-party recovery cannot be had in an amount at least equal to the benefits withheld, then in such event the Plan shall pay the withheld benefits reduced by the amount of any third-party recovery achieved.

## **E. Right of Offset and Recovery**

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

1. The Covered Person or his or her attorney if any, fails to fully comply with the provisions of this Section XI; or
2. 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.

## Section XII

### General Information about the Plan

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

1. The name of the Plan is the Carpenters' Health and Welfare Trust Fund of St. Louis.
2. The Plan Sponsor and Plan Administrator are the Board of Trustees of Carpenters' Health and Welfare Trust Fund of St. Louis.
3. The Plan Address and Contact Information are:

Carpenter's Health and Welfare Trust Fund of St. Louis  
1419 Hampton Avenue  
St. Louis, Missouri 63139  
Telephone: (314) 644-4802  
Toll Free: (877) 232-3863  
[benefits@carpdc.org](mailto:benefits@carpdc.org)

4. The Plan is a Welfare Plan providing benefits for Medical care, Prescription Drugs, Dental care, Vision care, Short Term Disability, Life, Accidental Death and Dismemberment, and Safety Enhancement.
5. The Trustees have exclusive discretionary authority to determine eligibility for benefits, to construe the terms of the Plan, and to make all other determinations as to whether any particular individual is entitled to receive any benefit. Benefit determinations of the Trustees shall receive the maximum deference permitted by law.
6. The Trustees may debar a Provider of services or supplies, if the Trustees determine in their discretion that the Provider has:
  - a. Submitted false or fraudulent claims; or
  - b. Failed to comply with the terms of its contract with a Network engaged by the Plan; or
  - c. Repeatedly submitted claims in a manner that results in harassment or unreasonable administrative efforts in processing the Fund.

No benefits will be due or paid by the Plan for services or supplies obtained from a debarred Provider during the period of debarment, which may be temporary or permanent.

7. 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 permits self-payments by underemployed, retired, disabled, and Self-Employed Members and surviving spouses, as well as COBRA continuation Premiums.
8. The Trustees have discretionary authority to contract with third parties to furnish any services and supplies that the Trustees believe are advantageous to the Plan and its Members and Dependents, such as, but not limited to, insurers of certain benefits, Networks of Providers of medical, dental, vision, or other covered services, Networks of prescription drug Providers, claims adjudication, case management, and administrative services.

## Section XIII

### Plan Definitions

Unless indicated otherwise in a specific context, words used in this booklet shall have the meanings set forth in this Section XIII. Please note there are other definitions set out in the body of this booklet. Whenever required by the context of any plan provision, the masculine includes the feminine; the feminine includes the masculine, the singular the plural, and the plural the singular. Any headings used in the booklet are included for reference only, and are not to be construed so as to alter any of the terms of the Plan.

1. **“Abortion”** means the termination of Pregnancy before the fetus reached the stage of viability
2. **“Active Work”** means the performance of work as an Eligible Member at such place as is required in the course of his employment.
3. **“Active Classification”** means the following classes of individuals:
  - a. Qualified actively working Members
  - b. Qualified Members covered by the Minimum or Difference Self-Payment provisions or COBRA Continuation Coverage
  - c. Self-Employed Members actively at work
4. **“Acute”** refers to an illness or Injury that is both severe and of recent onset.
5. **“Alternate Facility”** is a non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis, or Mental Health or Substance Abuse services on an inpatient or outpatient basis, pursuant to the law of the jurisdiction in which treatment is received, including without limitation:
  - a. Scheduled surgical services;
  - b. Emergency Health Services
  - c. Urgent Care Services, or prescheduled rehabilitative services;
  - d. Laboratory or diagnostic services.
6. **“Alternate Recipient”** is the child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.
7. **“Alcohol or Drug Dependency”** means the uncontrollable or excessive abuse of addictive substances and the resultant physiological dependency that develops with continued use, requiring care as determined by a Physician or psychologist. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.
8. **“Allied Health Professionals”** means Nurse Practitioners (NP), Certified Registered Nurse Anesthetists (CRNA), Physician Assistants (PA) and Certified Nurse Midwives (CNM) with respect to the services of such Providers specifically covered by the Plan and to the extent that such services are within the scope of the Provider's legally authorized practice and rendered under the direction of a Physician.
9. **“Ambulatory Surgical Center”** means a facility operated primarily for performing surgical procedures under the supervision of a staff of Physicians and that meets all of the following conditions:
  - a. It requires a licensed anesthesiologist to administer anesthesia and remain present during surgical procedures.
  - b. It provides at least two operating rooms and one post-operative recovery room.
  - c. It has X-ray and laboratory equipment.
  - d. It maintains written agreements with a Hospital or Hospitals concerning immediate admittance of patients who develop complications.
  - e. It maintains adequate medical records for each patient.
  - f. The facility does not provide accommodations for overnight stay.

10. **“Ancillary Service”** are those services not performed by an MD or DO and usually associated with, but not limited to lab, x-ray, nursing, dietary, pharmacy and rehabilitative services.
11. **“Appeal”** is 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.
12. **“Benefit Quarter”** means any of the three-month periods beginning January 1, April 1, July 1 and October 1 of each year.
13. **“Carpenters' Pension Plan”** refers to the Pension Plan of the Carpenters' Pension Trust Fund of St. Louis, the Kansas City Pension Plan, Kansas Building Trades Pension Plan or Geneva.
14. **“Credit Hour”** is 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 Credit 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 Short Term Disability benefits of this Plan, hours received and paid for as a result of picket duty (referred to as Picket Hours) will not qualify as Credit Hours.
15. **“Coinsurance”** is the percentage amount you must pay for a service or supply as defined by the benefit schedule.
16. **“Concurrent Care Review”** is a review for Medical Necessity with respect to an ongoing course of treatment previously approved by the Plan to be provided over a period of time or number of treatments. Concurrent Care Review involves either (1) a decision upon a request to extend the course of treatment; or (2) a decision to terminate or reduce the treatment before its scheduled expiration.
17. **“Contribution Quarter”** or **“Plan Quarter”** means any of the three-month periods beginning February 1, May 1, August 1, and November 1 of each year.
18. **“Copayment”** or **“Copay”** is a specified fixed dollar amount You must pay as a condition of the receipt of certain services as provided in the Plan.
19. **“Covered Charge”** or **“Covered Expense”** means only the expense incurred, or portion of such expense determined to be allowable after application of the appropriate discount, if any, for medical care, services or supplies that:
  - a. are prescribed by a Physician and are necessary in connection with the therapeutic treatment of the Injury or Sickness involved,
  - b. are listed as Covered Charges and are not excluded from payment of benefits by the Exclusions and Limitations of the Plan,
  - c. are recognized as generally accepted medical practice, and
  - d. are not in excess of the reasonable and customary charges for the same or similar medical care, services, and supplies.
20. **“Covered Individual”** or **“Covered Person”** means only a Member or a Member's Eligible Dependent who is eligible for benefits under the Plan in accordance with the Eligibility Section of this document.
21. **“Custodial Care”** is care when it is primarily for the purpose of helping the patient with activities of daily living or meeting personal needs and 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 includes rest cures, respite care, and home care which are or which could be provided by family Members or private duty caregivers.
22. **“Deductible”** refers to the amount of money a Member will need to pay before the Plan will start paying benefits on claims incurred.

23. **“Developmental Therapy”** means therapy designed to further growth or bring about improvement by gradual training adapted to the Covered Person’s physical and mental development.
24. **“Durable Medical Equipment”** means equipment that meets all of the following conditions:
  - a. It can withstand repeated use.
  - b. It is primarily and customarily used in the therapeutic treatment of Sickness or Injury.
  - c. It is generally not useful to a person in the absence of a Sickness or Injury.
  - d. It is appropriate for use in the home.
  - e. It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.
  - f. It is not primarily for the convenience of the person caring for the patient.
  - g. It is not used for exercise or training.
  - h. It is made and used externally to the human body for the therapeutic treatment of an Injury or Sickness.
25. **“Educational Therapy”** is therapy intended to further or promote the Covered Individual’s education or intended to educate the Covered Individual.
26. **“Eligibility Classes”** means the category or class a Covered Person becomes qualified for and maintains coverage.
27. **“Eligible for Medicare”** means that an individual is eligible to enroll and participate in the Medicare program by reason of attained age and/or entitlement to Social Security benefits.
28. **“Emergency”** means an illness, injury, symptom or condition that is severe enough (including severe pain), that if the patient did not get immediate medical attention it would be reasonable to expect one of the following to result: 1) The patient’s health would be put in serious danger; or 2) The patient would have serious problems with bodily functions; or 3) The patient would have serious damage to any part or organ of the patient’s body.
29. **“Employer”** means Employer as defined in the Carpenters' Health and Welfare Trust Fund Agreement.
30. **“Enrollment/Change Form”** is the required application for enrollment in the Plan.
31. **“Entitled to Medicare”** means that an individual is both Eligible for Medicare and enrolled in any part of Medicare.
32. **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended from time to time.
33. **“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.
34. **“Experimental or Investigative”** means in connection with a drug, device, treatment or procedure that:
  - a. with respect to the illness being treated, the drug, device, treatment, or procedure cannot be lawfully marketed in the U.S. or has not been approved by the U.S. Food and Drug Administration (FDA) at the time the drug or device is furnished; or
  - b. with respect to the illness being treated, the drug or device used in conjunction with a procedure that is not considered to be the standard of care; or
  - c. with respect to the illness being treated, the drug, device, treatment or procedure, or the patient informed consent document used with the drug, device, treatment or procedure, requires review and approval by the treating facility’s Institutional Review Board or other body serving a similar function, or if U.S. federal law requires such review and approval; or
  - d. with respect to the illness being treated, reliable evidence shows 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.
  - e. 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.

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

35. **“Home Health Agency”** means 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.
36. **“Hospice Agency”** means 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.
37. **“Hospice Care Program”** means a coordinated, interdisciplinary program to meet the physical, psychological and social needs of terminally ill persons (life expectancy of six months or less) and their families by providing palliative (pain controlling) and supportive medical, nursing and other health services through home or inpatient care during the Sickness or bereavement.
38. **“Hospital”** means 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 Individual.
39. **“Illegal Act”** is any felony or misdemeanor, or any other activity which is against civil or criminal law for which the Member was charged or arrested and is expected to be convicted.
40. **“In-Network”** or **“Network Provider”** means the Hospitals, Physicians, suppliers, ancillary Providers and other clinical facilities, pharmacies and vision care Providers who have a written agreement with the Network Sponsor to provide health care services and supplies to plan participants for a negotiated charge at the time the service or supply is provided. You may contact the Network at any time to determine a Provider’s participation status. An In-Network Provider is may be a regional Network or a national Network that the Plan has contracted with through a third party.
41. **“Infertility Services”** means those Health Services designed for the primary purpose of successfully fostering and achieving conception and Pregnancy.

42. **“Injectable”** medication is prescription medications injected by or under the direct supervision of a Physician.
43. **“Injury”** means a non-occupational bodily Injury caused directly and exclusively by external means with respect to which benefits are not payable under any Workers' Compensation, occupational disease or similar law.
44. **“Inside Eligibility Class”** means 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 one hundred and thirty-three (133) per month or a reduced contribution due to apprentice status.
45. **“Maintenance Therapy”** is 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.
46. **“Managed Mental Health and Substance Abuse Network”** means the organization with whom the Carpenters' Health and Welfare Trust Fund has contracted to administer the Managed Mental Health Care program.
47. **“Medical Care Management”** means the 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.
48. **“Medical Care Management Company”** means the organization with whom the Carpenters' Health and Welfare Trust Fund has contracted to administer the Managed Care program.
49. **“Medically Necessary” or “Medical Necessity”** means those services, supplies, equipment, and facility charges that are not expressly excluded under the Plan and are determined to the Plan to be:
- Medically appropriate, so that expected health benefits (such as, but not limited to, increase life expectancy, improved functional 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.
50. **“Member”** means an individual who is eligible for benefits, who is 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.
51. **“Medicare”** means the federal program of Health Insurance for the Aged and Disabled (Part A and Part B), otherwise referred to as Title XVIII of the Social Security Act.
52. **“Network Sponsor”** means a provider network the Plan has contracted with to provide access to their provider network services and for other administrative services such as utilization review.
53. **“Non-Active Classification”** means the following classes of individuals:
- Retired Members
  - Retired Self-Employed Members
  - Non-Pension Members
  - Disabled Members
  - Surviving Spouses

54. **“Non-Bargained Office Employee”** means any employee of a contributing Employer who executes a Participation Agreement For Non-Bargained Office Employees and is accepted by the Trustees other than:
  - a. An employee covered by a collective bargaining agreement requiring contributions to this plan or another health and welfare plan, or
  - b. Partner or sole proprietor of the Employer and any other person who is prohibited by law from participating in this plan.
55. **“Non-Compliant”** for purposes of the Spousal Coverage Program, Non-Compliant means a Member’s spouse who is eligible for health plan coverage through their own Employer and chooses not to enroll in their won Employer’s plan, or a Member’s spouse who does not properly complete the Verification Form for the Spousal Coverage Program.
56. **“Non-Exempt”** for purposes of the Spousal Coverage Program, Non-Exempt means a Member’s spouse who is required to enroll in health plan coverage through their own Employer.
57. **“Non-Pension Member”** means 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.
58. **“Occupational Therapy”** means the use of work-related skills to treat or train the Covered Individual, to prevent disability, and to restore the Covered Individual to health, social or economic independence.
59. **“Open Enrollment”** means the time or times during the year when an employee may normally enroll for coverage in an Employer-sponsored health plan.
60. **“Outside Eligibility Class”** means 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.
61. **“Out-of-Network”** or **“Non-Network”** means a health care provider who is not contracted with one of the Plan’s Network Sponsors.
62. **“Out-of-Pocket Maximum”** is the maximum amount Members will pay; once the Out-of-Pocket Maximum has been reached, the Plan will pay 100% of Covered Expenses for the rest of the calendar year.
63. **“Part-Time”** is defined as an employee who on average works less than 30 hours per week.
64. **“Pharmacy Benefit Manager and Network Sponsor”** means the organization with whom the Carpenters’ Health and Welfare Trust Fund has contracted with to administer the Prescription Drug Program.
65. **“Physical Therapy”** means 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.
66. **“Physician”** means only a legally qualified doctor of medicine (MD) or doctor of osteopathy (DO). The term "Physician" also includes a licensed clinical psychologist, a licensed doctor of chiropractic (DC), a doctor of podiatric medicine (DPM), a doctor of dental surgery (DDS), a licensed doctor of medical dentistry (DMD) and a licensed doctor of optometry (OD), with respect to the services of such Providers specifically covered by the plan and to the extent that such services are within the scope of the Provider's legally authorized practice.
67. **“Plan Year”** shall commence on May 1 of one year and end on April 30 of the succeeding year.
68. **“Post-Service Claim”** is an Appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
69. **“Pregnancy”** means the state of being pregnant, childbirth, miscarriage, and any complications arising from any of these conditions.
70. **“Premium”** is the monthly fee required for coverage under certain classes of coverage under the Plan.
71. **“Prior Authorization”** or **“Pre-Certification”** is the review and approval of requests for certain services and/or supplies. Services that require Prior Authorization or Precertification are reviewed by a team of

medical professionals prior to receipt of such services and supplies to determine Medical Necessity of care and that services are the standard of care.

72. **“Primary Care Physician” (PCP)** refers to a physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. Internal Medicine, Family Physician, OB-GYN, Pediatrician, Doctor of Osteopathy and General Medicine physicians are all considered Primary Care Physicians under the Plan.
73. **“Pre-Service Claim”** is an Appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided or requires Prior Authorization.
74. **“Preventive”** means the services are defined under the Affordable Care Act (ACA) as those immunizations, screenings and other ancillary services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA) and the federal Centers for Disease Control (CDC).
75. **“Provider”** means a Physician, Hospital, or other Provider of medical care, services or supplies. All providers must be licensed to provide services within the scope of their license by the state in which the services are rendered.
76. **“Qualified Medical Child Support Order (QMCSO)”** means a Medical Child Support Order issued by a court of competent jurisdiction or through an administrative process established under state law, which creates or recognizes the existence of an Alternate Recipient’s right to receive benefit for which a Member is eligible under the Plan in accordance with applicable state and federal laws.
  - a. A “Medical Child Support Order” is any judgment, decree, or order (including approval of a settlement agreement) which:
    - 1) provides for child support with respect to a 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
    - 2) is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.
77. **“Self-Employed”** for purposes under the Spousal Coverage Program means an individual, doing business as a sole-proprietor or partner, who either has not employees or offers non-health coverage to employees.
78. **“Self-Injectable”** medication is medication that is injected by the patient or patient’s caregiver.
79. **“Semi-private Accommodations”** is a room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary or when Semi-private Accommodations are not available and when an exception has been made by the Medical Director in advance of the admission. Exceptions may or may not be granted by the Plan.
80. **“Sickness”** means a non-occupational bodily disorder, disease, mental infirmity or Pregnancy with respect to which benefits are not payable under any Workers' Compensation, occupational disease or similar law. All Sicknesses that are due to the same or related cause or causes will be deemed one Sickness.
81. **“Skilled Nursing Facility”** means a legally-operated institution that:
  - a. specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis and is certified by Medicare,
  - b. maintains on the premises specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis,
  - c. maintains on the premises all facilities necessary for medical treatment,
  - d. for a fee provides convalescents with room, board and 24-hour skilled nursing care by one or more professional nurses and other nursing personnel needed to provide adequate medical care,
  - e. is under 24-hour supervision of a Physician or registered graduate nurse (RN),
  - f. keeps adequate daily medical records for each patient,

- g. if not operated by a Physician, has the services of one available under an established agreement, and
  - h. is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, drug addicts, alcoholics, or a facility for Custodial Care, remedial education or training.
82. **“Special Participation Eligibility Class”** means 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.
83. **“Speech Therapy”** means the remediation or rehabilitation for speech and language impairments.
84. **“Spousal Coverage Program”** is a plan provision that requires spouses who have access to Employer paid or partially paid health coverage through their Employers to enroll in coverage in order to be covered under this Plan as secondary.
85. **“Total Disability”** means 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.
86. **“Trust Agreement”** shall mean the Carpenters' Health and Welfare Trust Fund Agreement of May 1, 1953, as Restated December 11, 1975 and as further amended from time to time.
87. **“Trust Fund”** or **“Fund”** means the Fund established under the Trust Agreement that will receive contributions and from which any amounts payable under the Plan are to be paid.
88. **“Trustees”** shall mean the Trustees under the Trust Agreement.
89. **“Urgent Care Claim”** is an Appeal that must be reviewed under an expedited Appeal process because the application of non-Urgent Care Appeal time frames could seriously jeopardize:
- a. The life or health of the Member; or
  - b. The Member’s ability to regain maximum function.
  - c. 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:
    - d. Care that the treating Physician deems urgent in nature; or
    - e. 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 that is being requested.
90. **“Union”** means Union as defined in the Carpenters' Health and Welfare Trust Fund Agreement.

## Section XIV

### Miscellaneous Plan Provisions

1. **Information to be furnished** - Members and dependents shall provide the Benefit Office with such information and evidence and shall sign such documents, as may reasonably be requested from time to time, for the purpose of administration of the Plan. Each person entitled to benefits under the Plan must file at the Benefit Office, in writing, his Social Security number, his post office address and each change of post office address. Any communication, statement, or notice addressed to such person at his latest post office address as filed at the Benefit Office shall be binding on such person for all purposes of the Plan. The Trustees shall not be obliged to search for or to ascertain the whereabouts of any such person.
2. **Limitation of Rights** - Neither the establishment of the Plan, any amendment to the Plan, nor the payment of any benefits, will be construed as giving to any Member, dependent or other person any legal or equitable right against the Trust or any Employer, except as provided herein. This Plan shall not be deemed to constitute a contract between an Employer and any Member, or to provide any Member with a right to continued employment.
3. **No Guarantee of Tax Consequences** - Notwithstanding anything in this Plan Document to the contrary, the Trustees neither ensure nor make any commitment or guarantee that any amounts paid to or for a Member or dependent pursuant to the Plan will be excludable from the Member's gross income or wages for federal, state or local tax purposes.
4. **Facility of Payment** - If any person entitled to payments under this Plan shall be under a legal disability or, in the sole judgment of the Trustees, shall otherwise be unable to apply such payments to his own best interest and advantage, the Trustees, in their discretion, may direct such payments to be made:
  - a. To his court-appointed guardian or conservator, or
  - b. To his spouse, another Member of his family or to any other person, to be expended for his benefit, or
  - c. To an adult person designated by the Trustees as a custodian for him under the Missouri Transfers to Minors Law or similar statute, or
  - d. To an adult person designated by the Trustees as a personal custodian for him under the Missouri Personal Custodian Law or similar statute.Any payment made by the Plan in accordance with the above provisions shall fully discharge the Plan to the extent of such payments.
5. **Severability of Provisions** - The provisions of this Plan are severable, and should any provision be ruled illegal, unenforceable, or void, all other provisions not so ruled shall remain in full force and effect.
6. **Physical Exam and Autopsy** - The Trustees shall have the right and opportunity to examine the person with respect to whom benefits are claimed when and so often as they may reasonably require during pendency of claims hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.
7. **Legal Actions** - No action at law or in equity shall be brought to recover any benefit or payment under the Plan prior to the claimant's exhaustion of the claims and Appeals procedures set out in this Plan Document or until the Plan has failed to finally determine a claim within the time limits established for such determination, nor shall such action be brought at all with respect to uninsured benefits unless brought within two years from the earlier of the date the Trustees notified the claimant of their decision on Appeal or the date upon which such notification was due from the Trustees.
8. **Not Workers' Compensation Insurance** - The coverage provided by this Plan is not in lieu of and does not affect any requirements of coverage by Workers' Compensation Insurance.
9. **Rules of Construction** - The terms and provisions of this Plan shall be construed so as to bring the Plan into conformity with the Internal Revenue Code, ERISA and other governing federal law. The Plan shall be deemed to contain the provisions necessary to comply with such laws. If any provision of this Plan shall be

held illegal or invalid, the remaining provisions of this Plan shall be construed as if such provision had never been included. This restated Plan Document supersedes any and all prior Plan Documents.

10. **Right of Offset and Recovery** - If this Plan erroneously pays or overpays benefits to or for any person, the Trustees reserve the right to recover such erroneously paid amounts from any person or organization to whom or on whose behalf the benefits were erroneously paid. In addition, the Trustees have the right to offset the erroneous payment by reducing future benefits due either to the person on whose behalf the payment was made, or to any other individual in the group consisting of a Member and the Member's Dependents to which that person belongs. The Trustees may also bring a legal action against the person on whose behalf the payment was made and the Member related to such person. If the Trustees institute legal proceedings to collect erroneously paid benefits, and they prevail in such proceedings, both the person on whose behalf the benefits were paid and the related Member will be responsible for paying the Trustees; reasonable attorney's fees and costs. Section XI contains additional provision relating to the Trustees' rights of offset and recovery in the case of failure to reimburse benefits advanced when such reimbursement is due.
11. **Amendment or Termination** - 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.
12. **Examination of Records** – Subject to any restrictions imposed by law, the Plan Administrator will make available to each individual covered by this Plan such records of the Plan as pertain to him and as he is legally entitled to examine, for examination at reasonable times during normal business hours.
13. **Reliance on Other Information** - In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, the insurers or administrators of any of the benefits offered within the Plan, or by accountants, counsel or other professional advisers or experts employed or engaged by the Trustees.
14. **Nondiscriminatory Exercise of Authority** - Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.
15. **Source of Contributions** - Contributions to the Plan shall be made to the Trust Fund in accordance with the Carpenters' Health and Welfare Trust Fund Agreement and relevant collective bargaining agreements or other participation agreements.
16. **Named Fiduciary** – The Plan's named fiduciary is the Board of Trustees, with power to appoint investment managers, and also any person or entity designated by the Board of Trustees in writing as a named fiduciary of this Plan. Provided that the Board of Trustees may revoke at any time the designation of any person or entity as a named fiduciary, and may limit in any manner the authority of any named fiduciary to act on behalf of the Plan.

17. **Basis of Payments** - All Plan assets shall be used exclusively for the following:
- a. Payment of Plan benefits to Covered Persons;
  - b. Defraying reasonable expenses incurred in connection with the administration of the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator in connection with the administration of the Plan;
  - c. Payment of any insurance premiums necessary for the Trustees to purchase risk protection on any portion of the Plan's benefit liability, as determined by the Trustees.
  - d. Payment of any tax, premium or contribution required to remain in compliance with the Patient Protection and Affordable Care Act or other applicable law.
18. **Benefits are Not Vested** – No Covered Person, Provider, or any other person has a vested right to any Plan benefits or assets. The Trustees may, in their discretion, increase, reduce or eliminate any benefit at any time.