St. Louis-Kansas City Carpenters Regional Health Plan
Medical, Prescription, Dental & Vision Schedule of Benefits

CARPENTERS BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

Medical Schedule of Benefits

BENEFIT	Cigna Open Access Plus In-Network	Out-of-Network Providers
Annual Deductible – Member Responsibility	$300 Individual/$900 Family	$2,000 Individual/$6,000 Family
Annual Out-Of-Pocket Maximum – Member Responsibility	$2,300 Individual/$6,900 Family	$90,000 Ind/UnlimitedFamily
Coinsurance – Member Responsibility	20%	50%
PREVENTIVE CARE		
Routine Preventive Care	Plan Pays 100% Member Pays 0%	Plan Pays 50% Member Pays Deductible & 50%
Routine Mammogram	Plan Pays 100% Member Pays 0%	Plan Pays 50% Member Pays Deductible & 50%
Routine Colonoscopy	Plan Pays 100% Member Pays 0%	Plan Pays 50% Member Pays Deductible & 50%
OFFICE VISITS – NON-ROUTINE		
Primary Care Physician Office Visit	Member Pays $25 Copay	Plan Pays 50% Member Pays Deductible & 50%
Specialist Office Visit	Member Pays $50 Copay	Plan Pays 50% Member Pays Deductible & 50%
Mental Health and Substance Abuse Office Visit Psychiatrist All other providers (including, but not limited to: Counselors, Social Workers, Psychologists)	Member Pays $50 Copay Member Pays $25 Copay	Plan Pays 50% Member Pays Deductible & 50% Plan Pays 50% Member Pays Deductible & 50%
Cigna Telehealth Connection Services Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (details on myCigna.com). No charge for Medical and Behavioral Telehealth. **Note:** Telehealth visits performed by a physician outside of Telehealth Connection Services are subject to the Primary/Specialty Office Visit copays stated above.	Member Pays $0 Copay	Not Covered
OUTPATIENT SERVICES[1,3]		
Outpatient Surgery[1]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Active Members and Non-Medicare Retirees only Hearing Aid (Maximum $4,000 every 36 months)	Plan Pays 80% Member Pays Deductible & 20%	Same as In-Network
Lab, Radiology, Xray, Anesthesia, Pathology, and other Ancillary Services Independent Labs operate independently outside hospitals and include facilities such as LabCorp and Quest Diagnostics. Outpatient facilities for labs means an outpatient hospital-owned lab.	Independent Lab: Plan Pays 90%, No Deductible Outpatient Lab: Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
CT, PET, MRI Scans, Nuclear Scans and Other Diagnostic Services[1]	Plan Pays 80%, No Deductible	Plan Pays 50% Member Pays Deductible & 50%
Physical, Speech and Occupational Therapy[3]	Member Pays $25 Copay	Plan Pays 50% Member Pays Deductible & 50%
All other therapies – Includes Cognitive Therapy and Pulmonary Rehabilitation [3]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Durable Medical Equipment, Orthotics and Prosthetics[1]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%

BENEFIT	Cigna Open Access Plus	Out-of-Network Providers
Breast Feeding Equipment and Supplies Limited to the rental of one breast pump per birth as ordered or prescribed by physicians. Includes related supplies.	Member Pays 0% Coinsurance	Not Covered
Home Health Services/ Hospice[1]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Outpatient Mental Health and Substance Abuse – All Other Services[1]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Chiropractic Care - Limited to 40 visits annually X-rays performed in office, as a part of Chiropractic care, are not subject to the deductible under Chiro benefit - for IN or OON. Co-insurance for In-network is 0%, no deductible and out-of-network is 50%, no deductible. Does not include Interpretation. Does not include Advanced Radiological Imaging.	Member Pays $10 Copay	No Deductible Member Pays 50% coinsurance
INPATIENT SERVICES[1]		
Inpatient Hospital Services[1]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Convalescent Skilled Nursing Facility[1] Aggregate 100-day maximum cross accumulates among all benefit levels	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Mental Health Substance and Abuse Residential Care[1]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Observation Room[1]	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Physician Hospital Visits and Specialist Care/Consultations	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
Inpatient Ancillary Services (Emergency Room, Radiology, Anesthesiology, Pathology)	Plan Pays 80% Member Pays Deductible & 20%	Plan Pays 50% Member Pays Deductible & 50%
EMERGENCY AND URGENT CARE[2]		
Hospital Emergency Room[2]	Member Pays $250 Copay & 20% Coinsurance	Same as In-Network
Urgent Care Facility[4]	Member Pays $75 Copay	Plan Pays 50% Member Pays Deductible & 50%
Ambulance Service (Ground or Air)	Plan Pays 80% Member Pays Deductible & 20%	Same as In-Network

[1]Requires pre-certification through the Medical Care Management Company.

[2]In the event a patient is admitted through the Emergency Room, the Emergency Room copay is waived, and deductible/coinsurance applies. If an ER patient is not admitted as an inpatient, the Emergency Room copay and coinsurance are the only amount the Plan requires the patient to pay for all emergency services provided in the ER visit, regardless of whether any such services are billed separately or by a Non-Network Provider.

[3]Limited to combination of 60 visits annually.

[4]In an In-Network Urgent Care Facility, the copay is the only amount the Plan requires the patient to pay for all emergency services provided in the visit, regardless of whether any such services are billed separately or by a Non-Network Provider.

Prescription Schedule of Benefits

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

PRESCRIPTION BENEFIT SCHEDULE	MIN/MAX Copay per script		Member Coinsurance
Up to 30-day supply through Retail[1] or Mail Order			
Generic Medication	$10	$20	10%
Preferred Brand[2] Drug Medication	$20	$75	30%
Non-Preferred Brand[2] Medication	$30	$125	40%
Diabetes and Insulin Supplies *(including short-term continuous glucose monitors)*	$10	$50	10%
90-day supply through Retail[1] or Mail Order			
Generic Medication	$20	$40	10%
Preferred Brand[2] Drug Medication	$40	$150	30%
Non-Preferred Brand[2] Medication	$60	$250	40%
Diabetes and Insulin Supplies	$20	$100	10%
Non-Select Specialty Medications			
Preferred Brand[2] Drug Medication	$40	$150	35%
Non-Preferred Brand[2] Medication	$40	$250	40%
Select Specialty Medications			
Must Enroll in SaveonSP Program, call 800.683.1074	$0		0%
If Not Enrolled in SaveonSP Program	No MAX		30% Minimum
Select Specialty Drugs may be found on the SaveonSP Specialty Drug list: ***www.saveonsp.com/carpdc***			*Does not count toward out-of-pocket*
Individual Annual Out-of-Pocket	$3,500		
Family Annual Out-of-Pocket	$7,000		

[1]**Restricted Retail Pharmacy Network** – Medications for maintenance or long-term use must be filled by mail order or at a pharmacy participating in our Restricted Retail Pharmacy Network for a 90-day supply. The 90-day copay schedule above will apply. If mail order or the Restricted Retail Pharmacy Network is not used, you will pay the full cost of the drug. For a list of participating pharmacies on the Restricted Retail Pharmacy Network, log in or register at **express-scripts.com/90day** or call Express Scripts at 866.890.1419.

[2]**Member Pays the Difference** – When you fill a brand prescription when the generic equivalent is available, you pay the difference in the brand cost versus the generic cost plus the generic copay. Generic drugs are the same active chemical elements as the brand name drugs. Check with your doctor or pharmacist about taking advantage of generic drugs with lower copays. If you are not able to take the generic due to documented clinical reasons, please submit an appeal to pay the brand copay even though a generic is available.

Dental Schedule of Benefits

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

In-Network dental Providers are named and updated on the Delta Dental website at www.deltadentalmo.com/members/login.

Deductibles, Coinsurance and Maximum Benefit Limits

LIMITATION	PPO NETWORK	PREMIER NETWORK	NON-NETWORK[1]
Annual Deductible Preventive Services	Member Pays $0	Member Pays $50	Member Pays $150
Annual Deductible All Other Services, Cumulative	Member Pays $50	Member Pays $75	Member Pays $150
Preventive Services	Member Pays 0% Plan Pays 100%	Member Pays Deductible and 25% Plan Pays 75%	Member Pays Deductible and 50% Plan Pays 50%
Basic Services	Member Pays Deductible and 20% Plan Pays 80%	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 75% Plan Pays 25%
Major Services	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 60% Plan Pays 40%	Member Pays Deductible and 75% Plan Pays 25%
Orthodontic Services	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 50% Plan Pays 50%	Member Pays Deductible and 50% Plan Pays 50%
Annual Maximum Benefit, excluding Orthodontia*	Max Advantage** plus $1,500	Max Advantage** plus $1,500	Max Advantage** plus $1,500
Lifetime Maximum Benefit, Orthodontia Only	$1,500	$1,500	$1,500

[1]When using a Non-Network Provider, usual and customary allowance is applied to the claim. The difference in what the dentist bills vs. the usual and customary allowable is the responsibility of the member.
*Per Covered Person, except for Dependent Child prior to 19th birthday.
**Refer to Section IV,C,3 of the Plan Document regarding definition and detailed information regarding Max Advantage.

CLASSIFICATION AND LIMITATION OF COVERED DENTAL SERVICES
PREVENTIVE SERVICES

Diagnostic and Preventive Services	Services and procedures used to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Includes oral examination, prophylaxes (cleanings) and topical applications of fluoride. • Oral examinations and prophylaxes (cleanings) performed twice in a calendar year; if Medically Necessary, prophylaxes can be covered for up to four times per calendar year.

CLASSIFICATION AND LIMITATION OF COVERED SERVICES	
	• Fluoride treatments performed twice in a calendar year for patients up to age 19. • Brush biopsy to detect oral cancer.
Emergency Palliative Treatment	Nonspecific treatment used on an emergency basis to temporarily relieve pain.
Radiographs	X-rays as required or in conjunction with the diagnosis of a specific condition. • Bi-wing radiographs performed twice in a calendar year. • Full-mouth radiographs (which includes bitewing X-rays) performed once every three years.
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.
BASIC BENEFITS	
Sealants	Applied to the occlusal surface of molars that are free from caries and restorations, once per tooth per lifetime. • Benefits are payable for first and second permanent molars up to age 19 only.
Oral Surgery Services	Extractions and other surgical dental procedures; includes pre-operative and post-operative care.
Endodontic Services	Procedures used for the treatment of teeth with diseased or damaged nerves (root canals).
Periodontic Services	Procedures used for the treatment of diseases of the gums and supporting structures of the teeth including gum disease. This includes periodontal maintenance following active therapy (periodontal prophylaxes).
Minor Restorative Services	Services used to rebuild, repair, or reform the tissues of the teeth; includes amalgam, restorations (repair of crowns, or onlays), resin restorations, and relines and repairs to prosthetic appliances (bridgework and dentures).
MAJOR BENEFITS	
Prosthodontic Services	Services and appliances that replace missing natural teeth; includes fixed bridgework, partial dentures, complete dentures, and implants at the alternate treatment allowable.

Major Restorative Services	Services used to rebuild, repair or reform the tissues of the teeth when the teeth cannot be restored with another filling material, includes replacement of cast restoration (crowns), and jackets.
ORTHODONTIC BENEFITS	
Orthodontic Services	Services, treatment, and procedures required for the correction of malposed teeth.

Please refer to the Plan Document for detailed information.

Vision Schedule of Benefits

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

VISION SERVICE OR SUPPLY	Frequency	Description	VSP Provider*	Non-VSP Provider Maximum Benefit*
Routine Eye Examination	*Every calendar year*	Focuses on overall eye wellness	Member Pays $10 copay	Member Pays the Greater of $10 Copay or Balance after Plan Pays $38
Prescription Glasses				
Frames	*Every 24 months*	Included in Prescription Glasses	Member Pays $25 copay Plus 80% of Balance after Plan Pays $150	Member Pays the Greater of $25 Copay or Balance after Plan Pays $45
Lenses	*Every calendar year*	Single Vision	Plan Pays 100% No Member copay	Plan Pays $31 Member Pays Balance
		Lined bifocal	Plan Pays 100% No Member copay	Plan Pays $51 Member Pays Balance
		Lined trifocal	Plan Pays 100% No Member copay	Plan Pays $64 Member Pays Balance
		Lenticular	Plan Pays 100% No Member copay	Plan Pays $80 Member Pays Balance
Lens Enhancements	*Every calendar year*	Standard progressive	Plan Pays $50 Member Pays Balance	Not covered
		Premium progressive	Plan Pays $80 - $90 Member Pays Balance	Not covered
		Custom progressive	Plan Pays $120 - $160 Member Pays Balance	Not covered
Contacts (Instead of glasses)	*Every calendar year*	Medically necessary; prior authorization	Plan Pays 100% No Member copay	Plan Pays $210 Member Pays Balance
Contacts	*Every calendar year*	Elective	Plan Pays $150 (includes lens exam) Member Pays Balance	Plan Pays $105 (does not include lens exam) Member Pays Balance
ProTec Safety® (Member-Only Coverage) with VSP Provider Only				
Frames	*Every 24 months*	VSP doctor's ProTec Eyewear® collection Certified according to the ANSI guidelines for impact protection	Member Pays $25 copay	Not covered

VISION SERVICE OR SUPPLY	Frequency	Description	VSP Provider*	Non-VSP Provider Maximum Benefit*
Lenses	*Every 24 months*	Single Vision Lined bifocal Lined trifocal Certified according to the ANSI guidelines	Included with Frames	Not covered

*Subject to additional limitations set forth below. *The services and supplies listed in the Vision schedule are covered only if performed by a licensed optometrist, ophthalmologist, or dispensing optician. Covered eye exams include an evaluation of visual function and prescription corrective lenses, if needed.*