CARPENTERS' HEALTH AND WELFARE

TRUST FUND OF ST. LOUIS

HEALTH AND WELFARE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

JANUARY 1, 2006

carpenters' benefit plans
HEALTH & RETIREMENT SERVICES

CARPENTERS' HEALTH AND WELFARE TRUST FUND OF ST. LOUIS

Plan Document and Summary Plan Description of your Medical, Dental, Vision, Weekly Accident and Sickness Benefits, and Life and Accidental Death & Dismemberment Insurance

Introduction

The Trustees of the Carpenters' Health and Welfare Trust Fund of St. Louis (hereinafter referred to as the "Trustees") have previously established an employee welfare benefit plan providing medical, dental, vision, weekly accident and sickness benefits, life insurance, accidental death and dismemberment insurance and dependent life insurance, for the benefit of member of the Carpenters' Health and Welfare Trust Fund of St. Louis and the eligible dependents of such members.

In addition, Part 4 of Title I of the Employee Retirement Income Security Act of 1974 (hereinafter referred to as "ERISA") requires that each such employee welfare benefit plan be established and maintained pursuant to a written instrument. Previously, a description of benefits and other provisions of the plan were contained in the Plan of the Carpenters' Health and Welfare Trust Fund of St. Louis plan document.

At this time, the Trustees desire to revise the plan to amend certain plan provisions and to restate the Plan of the Carpenters' Health and Welfare Trust Fund of St. Louis plan document by presenting the document in combination with the summary plan description.

Therefore, effective January 1, 2006, the Plan of the Carpenters' Health and Welfare Trust Fund of St. Louis is amended and completely restated pursuant to the terms and conditions of this document.

CARPENTERS' HEALTH AND WELFARE
TRUST FUND OF ST. LOUIS

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St. Louis, MO 63139

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Health & Welfare Benefit Office Hours:

May 1 through August 31: 8 a.m. to 4 p.m. Monday through Friday
8 a.m. to 7 p.m. Tuesday

September 1 through April 30: 8 a.m. to 4 p.m. Monday through Friday
8 a.m. to 7 p.m. every 2nd and 4th Tuesday

BOARD OF TRUSTEES

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Carpenters' Health and Welfare Trust Fund of St. Louis
Plan of Benefits

ARTICLE I

ELIGIBILITY

This Article I sets forth the rules for determining eligibility for all benefits under this Plan except Safety Enhancement Benefits under Article VII. Eligibility for Safety Enhancement Benefits under Article VII is determined by the provisions of Article VII.

ELIGIBLE CLASSES OF EMPLOYEES

If you are employed in work covered by a collective bargaining agreement under the jurisdiction of the Carpenters' District Council of Greater St. Louis and Vicinity, you may become eligible for benefits as a member of this Plan. Eligible members may also include:

- Employees of:
  - Carpenters' District Council of Greater St. Louis and Vicinity;
  - Carpenters' Benefit Fund Office;
  - 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.
- Retired active members for whom the Carpenters' District Council of Greater St. Louis and Vicinity was the recognized bargaining representative when they were actively working or those who were employed by the Carpenters' District Council or the Carpenters' Benefit Fund Office.
- Members of a Special Participation Group with month to month eligibility. This includes some non-bargaining unit employees of contributing employers, other groups for whom contributions are made on a month-to-month basis, as well as self-employed persons who have signed a work agreement with the Carpenters' District Council of Greater St. Louis and Vicinity.

ACTIVE CLASSIFICATION

There are three categories of eligible members under the Active Classification. These include:

- Qualified actively working members who qualify under this classification
- Qualified members covered by the Minimum or Difference Self-Payment provisions
- Qualified Self-employed members

ELIGIBILITY CLASSES

There are three eligibility classes under the Active Classification. These include:

- Outside Eligibility - Members who are employed in work covered by a collective bargaining agreement or participation agreement requiring all hours for health and welfare be reported and paid.
- Inside Eligibility - Members who are employed in work covered by a collective bargaining agreement requiring hours up to a maximum of 133 for health and welfare be reported and paid.
- Special Participation Eligibility - Non-Bargained Office Employees who are employed by a contributing employer who executes a Participation Agreement For Non-Bargained Office Employees and is accepted by the Trustees, requiring fixed monthly contributions to the Plan and members who participate in the Plan as a self-employed.

INITIAL ELIGIBILITY - MEMBERS

OUTSIDE ELIGIBILITY

An active member in the Outside Eligibility class initially becomes eligible for benefits on the first day of the month following the member's completion of at least 500 credit hours during the preceding six consecutive months. **A 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 Weekly Accident and Sickness benefits of this Plan, hours received and paid for as a result of picket duty (referred to as Picket Hours) will not qualify as credit hours.

INSIDE ELIGIBILITY

An active member in the Inside Eligibility class initially becomes eligible for benefits on the first day of the month following the member's completion of at least 250 credit hours during the preceding six consecutive months. A 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.

SPECIAL PARTICIPATION ELIGIBILITY

An active member in the Special Participation Eligibility class hired by a participating employer will become covered on the first day of the month following the month in which the employer first makes a timely contribution on behalf of that employee.

ENROLLMENT – ALL CLASSES

For all classes of eligibility, you will be required to complete an "Enrollment and Change Form" before any benefits under this Plan will be paid. The Fund Office will provide this form for you in your new member packet. Because this form enrolls you for all the benefits of this Plan, it is important that it is filled out completely and returned to the Fund Office in a timely manner. Benefits cannot be paid until this form is completed and returned to the Fund Office. If you have any questions on this form, please contact the Fund Office.

INITIAL ELIGIBILITY – DEPENDENTS – ALL CLASSES

Dependent coverage will begin when your coverage begins. After your coverage begins, new dependents will automatically be covered upon becoming eligible. You should complete an Enrollment and Change Form whenever you have a change in your dependents due to birth, adoption, marriage, legal separation or divorce. Failure to give notice will cause a delay in the consideration of any possible claims. You may be required to furnish certain legal documents regarding the acquisition of new dependents before they may become eligible for coverage.

Your "eligible dependents" include your spouse and each of your unmarried children younger than age 19.

Your "spouse" is your legal partner in marriage, provided the union is by civil or religious ceremony performed in accordance with the laws applicable to the state in which you reside. For purposes of this Plan, "spouse" does not include status as a common law spouse.

An unmarried child who is age 19 or older is also eligible for coverage if one of the following conditions applies:

- He or she is between the ages of 19 and 25 and is a full-time student, enrolled in an accredited school and is dependent on you for principal support. To qualify your child as a full-time student, you must furnish the Fund Office with a written full-time student certification each semester from the school that includes the name of the school the student name, the number of hours enrolled and the required number of hours needed for full time status. If a child completes the spring semester and plans to continue in the fall semester, he or she will continue to be an eligible dependent through the summer, provided the child meets all the other eligibility rules for dependents. If the child does not actually resume full-time student status in the fall, coverage will end on the date the fall semester begins at the institution at which the child was previously enrolled.
- He or she is dependent on you for support because of a physical or mental disability and is incapable of self-sustaining employment at the time he or she reaches the maximum age for coverage as a dependent. In this situation, you must notify the Fund Office and submit proof of the child's disability within 31 days of the date he or she would otherwise become ineligible. A disabled child may be covered by the Plan as long as he or she remains incapacitated and dependent, provided you submit proof of the disability when requested.

In addition to your natural children, each of the following children will be considered to be your "child" for purposes of eligibility provided you furnish the majority of the child's support and maintenance and the child is:

- A stepchild who otherwise meets all other Plan eligibility requirements;
- A child younger than age 19 legally placed for adoption in your home, provided such child was properly enrolled for coverage on the date you assumed a legal obligation for total or partial support of such child

in anticipation of adoption and provided further the child otherwise meets all other Plan eligibility requirements;

- A child for whom you are the court-appointed guardian, provided the child otherwise meets all other Plan eligibility requirements and the Trustees approve the addition of the child; and
- A child you have adopted by judicial decree.

In addition, a child for whom the Plan is required to provide coverage pursuant to a Qualified Medical Child Support Order (QMCSO) issued on or after August 10, 1993, will be an eligible dependent. You may obtain a copy of the Fund's Qualified Medical Child Support Order procedures by contacting the Fund Office.

Parents or other relatives are not eligible for dependent coverage, even though you may financially support them.

Irrespective of the foregoing provisions, a person who would otherwise qualify as an eligible dependent shall not be covered or eligible for any benefits under this Plan if that person has medical coverage under another plan, and if the other plan would impose lower benefit limits for such person because of his or her coverage or eligibility for benefits in this Plan. This does not refer to other plans that coordinate benefits under rules similar to those of this Plan.

CONTINUING ELIGIBILITY – ACTIVE CLASSIFICATION

CONTINUING ELIGIBILITY – OUTSIDE ELIGIBILITY

Once you have established initial eligibility and are covered by the Plan, you will continue to be eligible based on benefit quarters that follow contribution quarters (Benefit quarters begin each January 1, April 1, July 1 and October 1) as follows:

- If you work at least 250 credit hours in a contribution quarter, your eligibility will be extended through the benefit quarter that next follows the contribution quarter (see chart below). This is referred to as the 250 Hour Test.
- If you have worked at least 1,000 credit hours during a 12 consecutive-month period ending with any month in a contribution quarter, your eligibility will be extended through the benefit quarter that next follows the contribution quarter. This is referred to as the 1,000 Hour Test.
- If the Fund Office can verify you earned and received at least 1,200 credit hours in the Plan year, your coverage will be extended until the end of the fourth full benefit quarter that next follows the end of that Plan year (April 30). For example, your eligibility will continue from July 1, 2005 through June 30, 2006, if the Fund Office can verify you earned and received 1,200 credit hours during the Plan year that begins on May 1, 2004 and ends on April 30, 2005. In order for your eligibility to continue under this provision, you must be eligible for employment with a contractor who is signatory to a labor contract with the Carpenters' District Council of Greater St. Louis and Vicinity or must be eligible to be employed by the Carpenters' District Council or the Carpenters' Benefit Fund Office. This provision is referred to as the 1,200 hour test and is only applicable to those members classified with Outside Eligibility.

CONTINUING ELIGIBILITY – INSIDE ELIGIBILITY

Once you have established initial eligibility and are covered by the Plan, you will continue to be eligible based on benefit quarters that follow contribution quarters (Benefit quarters begin each January 1, April 1, July 1 and October 1) as follows:

- If you work at least 250 credit hours in a contribution quarter, your eligibility will be extended through the benefit quarter that next follows the contribution quarter (see chart below). This is referred to as the 250 Hour Test.
- If you have worked at least 1,000 credit hours during a 12 consecutive-month period ending with any month in a contribution quarter, your eligibility will be extended through the benefit quarter that next follows the contribution quarter. This is referred to as the 1,000 Hour Test.

CONTRIBUTION QUARTER		BENEFIT QUARTER
Hours Worked Here	**Provides Coverage For**	**Eligibility Period Here**
August, September, October	➔	January, February, March
November, December, January	➔	April, May, June
February, March, April	➔	July, August, September
May, June, July	➔	October, November, December

Generally, your coverage under Outside or Inside Eligibility Class will end if you fail to qualify under at least one of the above provisions, unless you make self-payments to continue eligibility. Self-payments are discussed in a later section.

However, if you are unable to work sufficient hours to maintain active-hours eligibility due to an occupational or non-occupational disability, and you have worked at least 1,200 credit hours during the 12 consecutive months ending with the month in which the disability began, your eligibility under the Outside or Inside Eligibility Class will be automatically continued without contribution until the earlier of:

- The date your disability ends, or
- The last day of the benefit quarter during which you reach the first anniversary of the date the disability began.

This is referred to as the Disability Hour Test. If you are unable to work due to leave of absence, temporary layoff or retirement, or if you have any reason to be concerned about your continued eligibility, be sure to contact the Fund Office to determine what, if anything, you can do to assure continuity of eligibility under the Plan.

CONTINUING ELIGIBILITY – SPECIAL PARTICIPATION ELIGIBILITY

Once you have established initial eligibility and are covered by the Plan, the continuing eligibility of Special Participation Eligibility class is determined on a month-to-month basis, with contributions made by the Employer in one month paying for coverage for the following month.

TERMINATION OF COVERAGE – ACTIVE CLASSIFICATION

Subject to the self-payment provisions explained in the next section, your coverage will end on the earliest of the following dates:

- The date the Plan ends.
- The date you do not satisfy the requirements for continuing eligibility.
- The end of the period for which your final contribution for coverage is made.
- The date you falsify any information in connection with a claim for benefits or commit any action with the intent to defraud the Plan.

Your dependents' coverage will automatically end on the earliest of the following dates:

- The date your coverage ends under the Carpenters' Health and Welfare Trust Fund of St. Louis. However, if your eligibility classification is Outside or Inside Eligibility, in the event of your death, coverage for your dependents will be continued for a period of three consecutive months following the date of your death, or for the period of coverage earned based on your accumulated hours immediately preceding your death, whichever is greater. Coverage for members under the eligibility class of Non-Bargained Office Employees have no provisions for any extended coverage for dependents, other than COBRA continuation, after the death of the office employee.
- The last day of the period for which your final contribution for dependent coverage is made.
- The date the Plan ends.
- The date the dependent becomes covered as an employee under this Plan.
- The date the individual no longer qualifies as an eligible dependent under the Plan.
- The date a dependent falsifies any information in connection with a claim for benefits or commits any action with the intent to defraud the Plan.
- The date the dependent enters active duty in the uniformed services of any country.

However, coverage for you and your dependents may continue during a protected leave of absence, if required, in accordance with the Family and Medical Leave Act of 1993 (FMLA), provided your employer makes the required contribution to the Fund on your behalf. You will need to contact your Employer to determine if you are eligible for such continued coverage.

Coverage for you and your dependents may also be continued during a leave of absence protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), provided you pay the required premiums. Complete provisions regarding continued benefits under USERRA are contained in Appendix A.

Reinstatement Provisions – Active Classification

Outside and Inside Eligibility Class

If your coverage under the active classification of this Plan has ended, and if you are not participating as a self-pay member in the Non-Active Classification, your active coverage will be reinstated after you have worked at least 250 credit hours within a contribution quarter, as long as these credit hours are worked within one year of your termination date. The reinstated coverage becomes effective on the first day of the next benefit quarter.

If you do not qualify for reinstated coverage under the previous paragraph, you must again satisfy the initial eligibility requirements to regain active coverage. Page 11 of this booklet describes special limited reinstatement provisions for members in the non-active classification.

Special Participation Eligibility Class

If your coverage under the active classification of this Plan has ended, your active coverage under the Special Participation Eligibility class may be reinstated on the first day of the month following the month in which a timely contribution has been received on your behalf from a contributing employer accepted by the Trustees.

Self-Payment Provisions – Active Classification

Outside and Inside Eligibility Classes

The provisions of this paragraph apply to members under the Outside and Inside Eligibility Class in the active classification who do not satisfy the continuing eligibility requirements for active coverage, and who are not drawing a Normal, Supplemental, Deferred or Disability Pension under the Carpenters' Pension Plan (see definition in Appendix D). A member who fails to satisfy continuing eligibility requirements for active coverage and who is drawing one of these pensions can maintain non-active self-pay coverage for Retired Members under the provisions of this booklet (see page 10).

Members to whom this paragraph applies can maintain eligibility for medical, dental, vision and life insurance benefits for a limited period of time after loss of regular active coverage by qualifying for and paying a "Difference" or "Minimum" contribution to the Fund.

Members with Less Than 250 Credit Hours per Contribution Quarter

Difference or Minimum Payments

If, in a contribution quarter immediately following a period of eligibility, you have not received the minimum 250 credit hours required for continued eligibility, and do not meet any of the other continuing eligibility requirements, you may maintain your eligibility by paying a contribution directly to the Fund. To continue eligibility, you must pay the difference between your actual credit hours and the minimum 250 credit hours, multiplied by the current hourly rate of Employer Health and Welfare contributions, as specified in the labor agreements. The Fund Office will notify you if this occurs. It is important to note that this coverage is an alternate to COBRA Coverage, discussed in another section of this book. If you elect self payments, and do not reestablish eligibility through credit hours alone, you will not be offered COBRA coverage after your self-payment coverage ends.

Coverage may be continued by "paying the difference" or, if no hours were worked, by "paying the minimum" of 250 hours. **You may make a combination of Difference or Minimum Payments for no longer than six consecutive benefit quarters (18 months), provided you are not receiving a Normal, Supplemental, Deferred or Disability Pension under the Carpenters' Pension Plan or related pension fund**.

After you have continued your coverage through these minimum and/or difference payment arrangements for up to six such consecutive benefit quarters, you may continue your eligibility only by meeting the requirements for one of the following:

- Continuing Eligibility as discussed beginning on page 7;
- Reinstatement Provisions as discussed above; or
- Coverage under the self-pay Non-Active Classification discussed beginning on page 10.

After you have exhausted your Difference or Minimum payment option, you will not be eligible for Difference or Minimum payments again unless you have qualified for continued eligibility based on credit hours as an active member for *at least two consecutive benefit quarters*.

Note: Difference Payments and Minimum Payments are quarterly payments and due on the first day of the month prior to the applicable benefit quarter and must be received in the Fund Office within 30 days of the due date to be accepted. See payment schedule below:

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

SPECIAL PARTICIPATION ELIGIBILITY CLASS

Apart from COBRA continuation coverage, there are no provisions for extended coverage under the Active Classification for members and dependents under the Special Participation Eligibility Class.

SELF-PAYMENT PROVISIONS - NON-ACTIVE CLASSIFICATION

There are five categories of eligible members under the Non-Active classification. These include:

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

The Non-Active Classification allows qualified members and their eligible dependents to continue eligibility under the Plan after they no longer meet the requirements under the Plan for Eligibility for Active Classification.

Provided the applicable premium is paid, the benefits provided are similar to those under the Active Classification. However, some benefits are different or not available for the Non-Active Classification.

Members under the Non-Active Classification may purchase, as an option, the Vision and Dental benefit package in addition to the medical benefits for an additional premium.

Non-Bargained Office Employees (see definition) do not qualify for participation under the Non-Active Classification.

Retired Members

For purposes of the retiree non-active classification, an individual retires at the time he or she begins to receive pension benefits from the Carpenters' Pension Plan.

An active member who retires while covered under this Plan by reason of employment pursuant to a collective bargaining agreement or employment with the Carpenters' District Council or Carpenters' Benefit Fund Office, or while covered as a disabled member, will be eligible for retiree non-active coverage on a self-pay basis, which covers the member and, for additional premium, his or her eligible dependents. Such a member who retires with regular active coverage must apply for retiree coverage by the first day of the month following the month in which the member's regular active coverage ends. A member who retires while covered by Minimum/Difference payments must apply for retiree coverage by the first day of the month following that period of Minimum/Difference coverage.

Retired Self-Employed Members & Non-Pension Members

Self-employed members and Non-Pension members who are not eligible to receive a pension or to participant in the Carpenters' Pension Plan may still qualify to participate in the Health and Welfare Plan under the Non-Active Classification. However, in order to be eligible, a self-employed member must have attained age 62 and must have contributed to this Fund as an active self-employed member for five consecutive years. A collectively bargained member who is not eligible to participate in the Carpenters' Pension Plan must indicate he or she has ceased working permanently and is eligible for self-payment coverage. Members must elect this self-payment coverage on or prior to the earlier of the following dates:

- The first day of the month following the last day of eligibility under the active classification.
- The first day of the month in which the member ceases all employment.

A member formerly covered in this Plan by reason of employment pursuant to a collective bargaining agreement or employment with the Carpenters' District Council or Carpenters' Benefit Fund Office, or while covered as a disabled member, who is not covered as an active or disabled member at the time he or she retires, must qualify under the Non-Active Reinstatement provisions of the Plan explained below.

Disabled Members

Disabled members may continue eligibility on a self-pay basis by timely submitting satisfactory evidence of total disability to the Fund. For purposes of this eligibility provision, total disability means a 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.

To qualify for this coverage, members must apply for coverage under this self-payment provision on or prior to the first day of the month following termination of active coverage.

The member must provide acceptable medical evidence of his or her disability in order to initially qualify for this coverage, and the Fund Office may require periodic evidence of the continuing disability. Eligibility for this coverage will end if the member's total disability ends.

Working under the Non-Active Classification

Members who earn credit hours while maintaining eligibility under any of the non-active self-payment provisions are entitled to receive a credit against their self-payment, in the amount of the employer contributions received by the Fund on account of hours worked, not to exceed the amount of the self-payment. Members who maintain eligibility under the non-active self-payment provisions generally may not qualify for coverage on an active basis as the result of hours worked. However, such a member will be provided with a one-time opportunity to re-qualify for eligibility and coverage under the Active Classification provided:

- he or she notifies the Fund Office in advance of the intent to have credit hours applied to reinstate eligibility on an active basis, in which case employer contributions will cease to be credited against self-payments, and
- he or she meets the initial eligibility requirements for coverage on an active basis maintaining non-active coverage with self-payments.

In this situation, the coverage under the Active Classification will become effective the first day of the month following completion of at least 500 credit hours during the preceding six consecutive months.

A member may move from Non-Active to Active only once in his or her lifetime.

Surviving Spouse

In the event of your death while covered, your surviving spouse may continue coverage under the Plan, but only until the date the surviving spouse remarries. To qualify for coverage under this self-pay category, your surviving spouse must apply for coverage at least 30 days after termination of coverage.

Your dependents who were eligible at the time of your death will continue to be covered while your surviving spouse is eligible for benefits, so long as your surviving spouse furnishes the majority of your dependents' support and pays the applicable premium and they satisfy all other requirements for dependent eligibility.

Reinstatement Provisions – Non-Active Classification

If, for any reason, you allow your or your dependents' Active or Non-Active coverage to end resulting in non-continuous coverage or a "break" in coverage, Non-Active coverage may begin or be reinstated only if you or your dependents have or had other group health coverage that was provided as a result of your own or your spouse's employment, and that coverage either remains in effect or was in effect within 63 days prior to the requested effective date for reinstated coverage and you or your dependents satisfy all other requirements to participate in the Plan under the Non-Active Classification, and you or your dependents meet one of the following additional requirements at that time:

- Not more than five years have elapsed since your or your dependents' coverage under the Active or Non-Active Classification in this Plan ended; or
- Continuously since termination of coverage in the Active Classification of this Plan ended, you have been employed by an employer obligated to contribute to this Plan for Carpenter employees.

As exceptions to the foregoing provisions, coverage cannot be reinstated under this Plan to a person who is currently covered by any Medicare HMO. Medicare HMO plans are an alternative to participating under the Non-Active Classification of this Plan.

Surviving spouse coverage must be continuous. If surviving spouse coverage ends, it may not be reinstated.

If you qualify for reinstatement based on the guidelines listed above, the coverage will be effective on the first day of the month following the month an appropriate contribution is made.

Life Insurance benefits are not available to any individuals whose non-active coverage is reinstated under these provisions.

NON-ACTIVE COVERAGE AND MEDICARE

If a surviving spouse or a retired, self-employed retired, non-pension retired or disabled member, or his or her dependents becomes eligible for Medicare, the Medicare Supplemental expense coverage described in this booklet will apply.

PAYMENT FOR COVERAGE UNDER NON-ACTIVE CLASSIFICATION

Retired, self-employed retired, non-pension retired, disabled members and surviving spouses who choose to participate are required to contribute a monthly amount directly to the Fund, as determined and published periodically by the Trustees. Contribution amounts vary under each category depending upon the coverage selection, the member's dependent status and Medicare eligibility status.

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 Health and Welfare Fund Office within 30 days of the due date to be accepted.

No Weekly Accident and Sickness Benefits

Self-paying non-active members who become disabled during a period in which their eligibility is established solely by self-payment are not eligible to receive weekly accident and sickness benefits.

MEDICAL PLAN OPTION FOR RETIRED EMPLOYEES – MEDICARE HMO PLAN

If you qualify for coverage under the Non-Active Classification and are covered by Medicare A and B, you may either continue participation in this Plan, or you may instead elect coverage under a Medicare HMO in place of any medical benefits under this Plan, provided you pay any contribution required by the Medicare HMO. A "plan-approved Medicare HMO" is a Medicare HMO with which this Plan has made arrangements to assist members who wish to enroll. If you enroll in a plan-approved Medicare HMO, you will receive a certificate of coverage directly from the HMO. Additional information concerning the plan-approved Medicare HMO(s) may be obtained from the Fund Office.

If you choose coverage under any Medicare HMO, all your medical benefits under this Plan will end -- you may not receive benefits under both plans.

If you have eligible dependents covered by this Plan when you retire, you may still choose plan-approved Medicare HMO coverage for yourself. Your eligible dependents will continue to be covered under this Plan, provided the dependents remain eligible, and you continue to pay the necessary contributions for coverage.

If you choose plan-approved Medicare HMO coverage, your life insurance benefit under this Plan will remain in effect, provided you or your dependents are not considered reinstated. You will have the option to purchase dental and vision coverage under this Plan for an additional premium.

If you are not satisfied with the service or coverage provided by a plan-approved Medicare HMO, you may transfer back to this Plan. To transfer coverage, you must follow the disenrollment procedures outlined in your Medicare HMO policy and request the transfer. Your coverage under this Plan will begin on the date your coverage under the Medicare HMO ends. Please note that you may request a transfer only once during your lifetime.

COBRA CONTINUATION COVERAGE

GENERALLY

What COBRA Coverage Is

The Carpenters' Health and Welfare Fund provides continued health and welfare coverage on a self-pay basis as required by the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Eligible employees, their dependents, or both are offered the opportunity for a temporary extension of health coverage called "continuation coverage" in certain instances called "qualifying events," which would normally otherwise cause coverage to end.

The qualified beneficiary does not have to show that he or she is insurable to qualify for continuation coverage. However, the qualified beneficiary must pay the cost of the continuation coverage.

COBRA continuation coverage is available only as an alternative to coverage provided under the self-pay provisions of the Plan. If you or a dependent chooses to continue coverage under any of the self-pay provisions, COBRA is not available when the self-pay period expires.

Who May Elect COBRA Coverage

Individuals who may elect COBRA coverage are referred to as "qualified beneficiaries." Each employee and eligible dependent who was covered under the Plan on the day before one of the qualifying events described below and whose coverage will terminate because of the qualifying event, is a qualified beneficiary entitled to make his or her own decision regarding COBRA continuation coverage. This is true even if the former employee chooses not to continue coverage. However, one family member can elect and pay for coverage on behalf of all qualified beneficiaries.

In addition to the member's dependents who were covered under the Plan on the day before the qualifying event, any child born to or placed with the member for adoption while the member has COBRA continuation coverage will also have an independent right to elect to retain COBRA coverage for the balance of the original COBRA period in the event the member's continuation coverage ends before the end of the maximum period.

Contact for COBRA Questions

If you or a dependent has any questions regarding this Plan's COBRA continuation coverage, call or write:

Carpenters Health and Welfare Fund Office
ATTENTION: COBRA Coordinator
1419 Hampton Avenue
St. Louis, Missouri 63139
(314) 644-4802
(877) 232-3863 (Toll-free)

QUALIFYING EVENTS THAT GIVE RISE TO RIGHT TO ELECT COBRA CONTINUATION COVERAGE

For Employees

As an employee of a contributing employer for whom the contributing employer is making contributions to this Plan, you will have the right to choose COBRA continuation coverage, if you lose your coverage under the Plan due to:

- A reduction in your hours of employment; or
- Termination of your employment for reasons other than gross misconduct on your part.

For Dependents

Your dependents who are covered by the Plan have the right to choose continuation coverage if they lose coverage under the Plan for any of the following reasons:

- Your death*;
- The termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment;
- Your divorce or legal separation;
- Your becoming eligible for Medicare; or
- Your dependent child's ceasing to qualify as an eligible dependent under this Plan (for example, your child reaches the upper age limit or gets married).

**COBRA is available to your surviving dependents only to the extent that they have not already had 36 months of coverage, on the same or more favorable terms as COBRA continuation coverage, under the surviving dependents self-pay provisions of this Plan.*

Benefits Available under COBRA Continuation Coverage

Continued coverage will be the same medical, dental and vision coverage to which you or your dependent(s) would have been entitled if the qualifying event had not occurred. Any future changes in the benefits or cost of coverage for the Plan will also apply to individuals on COBRA coverage. Qualified beneficiaries who elect continued coverage have the opportunity to add dependents or change coverage under the same rules that apply to actively working members under the Plan.

Life insurance and accidental death and dismemberment coverage cannot be continued under COBRA. However, you may be able to convert to an individual policy of life insurance. Weekly accidental and sickness benefits cannot be continued under COBRA.

REQUIRED NOTICES, ELECTION, AND PAYMENTS

Notices the Qualified Beneficiary Must Furnish to the Plan

Original Qualifying Event

Under the law, the eligible employee or dependent, or his or her representative, has the responsibility to provide written notice to the Fund Office of a divorce, legal separation, or a child losing eligible dependent status under the Plan within 60 days after the date of the latest of:

- Such event; or
- The date coverage would terminate because of that event; or
- The date the Plan provides the original notice of both the individual's responsibility to furnish notice of a qualifying event to the Fund Office and an explanation of how to give such notice to the Fund Office.

IMPORTANT NOTE: If a qualified beneficiary (or representative) fails to give the Fund Office one of these required notices within the required time, all rights to COBRA coverage terminate.

Second Qualifying Event

In addition, if a person who is on COBRA continuation coverage has a second qualifying event, that person, or his or her representative, must provide written notice to the Fund Office of that second qualifying event no later than 60 days after the latest of:

- the date of the second qualifying event;
- the date coverage would otherwise terminate; or
- the date on which the Plan provides the original notice of the responsibility to provide the Fund Office with notice of a second qualifying event and an explanation of how to give such notice to the Fund Office.

Notice of Social Security Disability Determinations

Finally, if a qualified beneficiary is eligible for Social Security disability, a qualified beneficiary seeking to extend his or her maximum period of COBRA continuation coverage based on that disability, or such qualified beneficiary's representative, must provide notice to the Fund Office of that Social Security determination both prior to the end of the original 18-month maximum continuation period and no later than 60 days following the latest of:

- the date of the Social Security determination;
- the date of the qualifying event; or
- the date on which the Plan provides the original notice of the responsibility to provide the Fund Office with notice of the Social Security determination and an explanation of how to give the Fund Office such notice.

If a qualified beneficiary's disability under Social Security ends, the qualified beneficiary, or his or her representative, must provide the Fund Office with notice of this no later than 30 days after the latest of:

- the date of Social Security's final determination that the individual is not disabled; or
- the date on which the Plan provides the original notice of both the qualified beneficiary's responsibility to furnish the Fund Office with notice of the termination of Social Security disability and an explanation of how to give the Fund Office such notice.

How to Give Notice

To give any of the above notices, you or your dependent should write to the Fund Office at the address listed below and include the following information:

- Name and social security number of employee;
- Names and addresses of dependents who will lose coverage;
- Date of qualifying event;
- Nature of qualifying event; and
- When the notice is required with respect to a Social Security disability determination, a copy of the determination.

Carpenters Health and Welfare Fund Office
ATTENTION: COBRA Coordinator
1419 Hampton Avenue
St. Louis, Missouri 63139
(314) 644-4802
(877) 232-3863 (Toll-free)

The employer making contributions on behalf of an employee has a responsibility to notify the Fund Office of the employee's death, termination of employment, or reduction in hours of employment, or your Medicare eligibility. Nevertheless, employees and their dependents are encouraged to provide the Fund Office with written notification of these events as well.

Plan's Notice to Qualified Beneficiaries

Within 30 days after the Fund Office receives notice that one of the qualifying events has occurred, it will in turn notify the qualified beneficiaries (you, your dependent(s), or both, as applicable) of the procedures for electing COBRA continuation coverage.

Election and Time Limit

Under the law, a qualified beneficiary has 60 days from the later of:

- the date he or she would lose coverage because of one of the events described above, or
- the date he or she is notified of his or her continuation rights.

A qualified beneficiary elects COBRA continuation coverage by returning a completed COBRA election form to the Fund Office within the 60 day period.

If a qualified beneficiary does not complete and return an election form to the Fund Office within the required time, all rights to continue coverage will end.

Payment

COBRA continuation coverage is not free. A qualified beneficiary must pay for it. The charge is set by the Trustees from time to time and is the full actual cost of coverage, plus any additional amount permitted by law.

The initial payment is due within 45 days after the date a qualified beneficiary makes an election. (This is the date the election form is post-marked, if mailed and the date the Fund Office receives the completed election form if it is hand-delivered.) 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, but will be accepted for up to 30 days after the due date.

After the initial election notice, the Plan does not send monthly bills or reminders that payment is due. It is the responsibility of the qualified beneficiary or his representative to make each payment within the 30-day grace period.

Coverage during Election Period and Payment Periods

After regular coverage ends and before a qualified beneficiary submits both the election form and the payment for COBRA continuation coverage, the Plan cannot pay any claims. If a provider inquires about whether a qualified beneficiary has coverage, the Fund Office will inform the provider that he or she is in the COBRA election and payment period. If the qualified beneficiary ultimately elects and pays for COBRA within the time limits, the Plan will process claims incurred during the election and payment period.

Similarly, if a qualified beneficiary does not make a monthly payment by the due date, benefits will be interrupted until the monthly payment is received. If payment is ultimately made prior to the end of the 30-day grace period, claims incurred during the grace period will be processed.

DURATION OF COBRA CONTINUATION COVERAGE

Termination or Reduction of Hours of Employment

Generally

If the qualifying event is the termination or reduction in hours of employment, the maximum period of COBRA continuation coverage ends 18 months after the date of the qualifying event. However, if your employment ends during a leave of absence protected by the Family and Medical Leave Act, the 18 months is measured from the date the protected leave ends.

Extensions of 18-Month Period

Disability

If prior to the end of that 18-month period, any of the qualified beneficiaries who elected COBRA is determined by Social Security to have been disabled during the first 60 days of COBRA continuation 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. If the disabled person is covered during this 11-month extension, the monthly cost will be 50% higher.

Medicare Eligibility

If you were eligible for Medicare at the time of the qualifying event, the COBRA continuation coverage period for your dependents will not end until 36 months after the date you became eligible for Medicare. For example, if you became eligible for Medicare in May of 2004, and then terminated employment in June of 2004, your COBRA period ends December of 2005, but your eligible dependents can continue their COBRA coverage until May of 2007, which is 36 months after your Medicare entitlement.

Second Qualifying Event

If a second qualifying event occurs during the 18-month (or 29-month) period, the maximum continuation period will be extended to 36 months from the date of the original qualifying event for the qualified beneficiaries affected by that second qualifying event. For example, if your employment is terminated on December 31, 2004, you and your eligible dependents are entitled to COBRA continuation coverage until June 30, 2006. However, if in May of 2005, your child turns 19 and is not a full-time student, that child has had a second qualifying event, and his or her COBRA continuation period can continue until December 31, 2007 (36 months from the date of the original qualifying event).

Other Qualifying Events

For all qualifying events other than the termination of employment or the reduction in hours of employment, the maximum COBRA continuation period is 36 months from the date of the qualifying event.

Termination of COBRA Continuation Coverage

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

- The expiration of the applicable maximum COBRA continuation period;
- The payment due date, if payment is not made before the end of the applicable grace period;
- After the date that COBRA is elected, the qualified beneficiary 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.
- The Carpenters' Health and Welfare Trust stops providing group health benefits.
- Keep Fund Office Informed of Addresses

In order that the Plan can make sure that you and all of your covered dependents get all of the notices about COBRA, please keep the Fund Office informed of your current address and the addresses of any covered dependents not living in your home.

SPECIAL COBRA RULES FOR INDIVIDUALS ELIGIBLE FOR TRADE ADJUSTMENT ASSISTANCE

Trade Act – Generally

The Trade Act of 2002 provides that certain workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may be determined by the United States Department of Labor or other government agency to be eligible for "trade adjustment assistance" or "TAA."

Special Election Period

If you do not take COBRA during the normal election period and are determined to be eligible for TAA, you will be entitled to a second 60-day COBRA election period. That second 60-day period will begin on the first day of the month in which you are determined to be eligible for TAA, but you must make your election no later than six months after your active coverage under the Plan ends.

Commencement of Premiums and Coverage

If you elect to take COBRA during this second special election period, your COBRA coverage will begin the first day of the special second 60-day election period. Your first payment will be due within 45 days after

you make your election and must include all payments due between the first day of the second election period and the date of payment.

Pre-Existing Condition Rules

If you elect coverage under these special rules, the period of time between your original loss of coverage and the date your coverage recommences under these special rules will not be counted for purposes of determining whether you have had a 63-day gap in coverage for purposes of applying this Plan's (or any other plan's) pre-existing condition limitations.

Additional Information

If you have any questions about how this Plan's COBRA provisions apply, contact:

Carpenters Health and Welfare Fund Office
ATTENTION: COBRA Coordinator
1419 Hampton Avenue
St. Louis, Missouri 63139
(314) 644-4802
(877) 232-3863 (Toll-free)

HIPAA CERTIFICATES

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), the Fund Office will provide you and your dependents with a HIPAA certificate when coverage under this Plan terminates. This certificate will show the length of time you, your dependents, or both were covered under this Plan. You or a dependent may need to show such a certificate to the next group health plan under which you or a dependent has coverage so that plan can determine whether it can apply a limit to any pre-existing condition you or a dependent may have.

This Plan will furnish such a certificate when regular coverage under this Plan ends, when COBRA coverage ends, and upon the request of the covered person within the two years following the termination of coverage.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov.ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

ARTICLE II

SCHEDULE OF BENEFITS

BENEFIT	IN NETWORK PROVIDER	NON-NETWORK PROVIDER	OUT-OF-AREA NETWORK PROVIDER
Annual Deductible Individual Family	 $0 $0	 $400** $800**	 $200** $400**
Coinsurance	100%	70%*	90%*
Individual Out-of-Pocket Maximum[1] (includes deductible)	N/A	$3,000*	$1,000*
Lifetime Maximum	$2,000,000	$1,000,000	$2,000,000
OUTPATIENT SERVICES			
Pre-certification Requirements (Pre-certifications must go through Medical Care Management Company)	In-Network Provider has Responsibility.	Member has responsibility	Member has responsibility
Primary Care Physician Office Visits	$20 co-payment	70%*	$20 co-payment
Specialist Physician Office Visit	$40 co-payment	70%*	$40 co-payment
Preventive Health Services Routine Physicals (includes annual school physicals, immunizations, pap smears and prostate screenings up to $500 per person per calendar year) Mammograms (per schedule)	 $20 co-payment 100%	 70%* 100% (maximum benefit $100)	 $20 co-payment 100%
Immunizations recommended by the Center For Disease Control for patients through age 24	100%	70%*	100%
Surgical procedure in Physician's Office	100%	70%*	90%*
Obstetrical Care[8] Delivery	$20 co-payment; first visit only 100%	70%* 70%*	$20 co-payment; first visit only 90%*
X-ray	100% If performed by In-Provider	70%*	90%*
Laboratory	100% If performed by In-Provider	70%*	90%*
CT, PET, MRI Scans, Bone Mineral Density Testing, Nuclear Scans[8, 10]	$50 co-payment	70%*	$50 co-payment
Other Diagnostic Services[8]	100%	70%*	90%*
Anesthesia	100%	70%*	90%*
Allied Health Professional Services	100%	70%*	90%*
Physical, Speech and Occupational Therapy Services[7, 8]	$5 co-payment	70%*	$5 co-payment
Inhalation Therapy	100%	70%*	90%*
Radiation Therapy[8]	100%	70%*	90%*
Injectables, Casts, Dressings, and Other Treatment Materials provided in a Physician's Office	100%	70%*	100%
Allergy Testing (Office Visit) Treatment/Injections	$40 co-payment 100%	70%* 70%*	$40 co-payment 90%*
Outpatient Surgical Facility[8]	$100 co-payment	70%*	$200 co-payment
Home Health Services[2, 8] (maximum 100 visits per calendar year)	100%	70%*	90%*
Hospice	100%	70%*	90%*
Ambulance Service	$50 co-payment	$50 co-payment	$50 co-payment
Durable Medical Equipment[8]	10% co-pay – Maximum $200	70%*	10% copay – Maximum $200

BENEFIT	IN NETWORK PROVIDER	NON-NETWORK PROVIDER	OUT-OF-AREA NETWORK PROVIDER
Chiropractic Care[7] ($1,500 annual benefit maximum cross accumulates among all benefit levels)	Maximum of $42 per visit.	Plan pays a maximum of $42 per visit. Member can be billed for balance.	Plan pays a maximum of $42 per visit. Member can be billed for balance.
INPATIENT SERVICES			
Pre-certification Requirements (Pre-certifications must go through Medical Care Management Company)	In-Network Provider has Responsibility.	Member has responsibility	Member has responsibility
In-Patient Hospital Services/Surgery[8] (including operating room, anesthesia, intensive care or other special care units)	$150 co-payment per admission	70%*	$250 co-payment per admission, then 90%
Obstetrical Delivery[8] Mother Newborn[9]	$150 co-payment per admission $150 co-payment per admission	70%* 70%*	$250 co-payment per admission, then 90% $250 co-payment per admission, then 90%
Physician's Hospital Visits and Specialist Care/Consultations	100%	70%*	90%*
Convalescent Skilled Nursing Facility[4, 8] (Aggregate 100-day maximum cross accumulates among all benefit levels)	100%	70%*	90%*
Hospice	100%	70%*	90%*
EMERGENCY AND URGENT CARE[5]			
Hospital Emergency Room Urgent Care Facility	$100 co-payment (In-Patient co-pay applies if admitted) $25 co-payment	$100 co-payment (In-Patient co-pay applies if admitted) 70%*	$100 co-payment (In-Patient co-pay applies if admitted) $25 co-payment

MENTAL HEALTH AND SUBSTANCE ABUSE - ALL SERVICES MUST BE AUTHORIZED AND PROVIDED BY UNITY HEALTH NETWORK	
Physician's Office *Individual Therapy* *Group Therapy*	 $20 co-payment $10 co-payment
Intensive Outpatient Treatment, Partial Hospitalization and Residential Facilities[1, 3] (maximum 15 days per category per calendar year)	90%
Inpatient Mental Health and Alcohol/Substance Abuse (30-day maximum per calendar year)[1]	90%

**After applicable deductible has been met.*
***Deductible waived for charges incurred in 2004, 2005, and 2006. This will allow members to convert to the In Network.*

1. Out-of-Pocket maximum cross accumulates for PPO and Non-Network providers. Coinsurance and co-payment amounts for mental health and substance abuse treatment and prescription drugs do not apply toward the out-of-pocket maximum.
2. Care must begin within seven days following a confinement of at least three days, or be through the Managed Care Program.
3. May substitute two days of partial hospitalization, intensive outpatient treatment or residential treatment for one day of inpatient hospitalization, if available.
4. Confinement must begin within seven days after discharge from a hospital confinement of three or more consecutive days, or within seven days after a previous covered skilled nursing facility confinement, or be certified through the Managed Care program.
5. Initial emergency room care, as defined by the Plan, will always be paid at 100% (after co-payment) regardless of the provider chosen. Urgent care expenses will be paid at the benefit level corresponding to the provider of care.
6. Coverage for prescriptions filled at a non-network pharmacy is provided in emergency situations.
7. Physical Therapy visits must be prior-authorized and performed by a licensed Physical Therapist.
8. May require pre-certification through the Managed Care Company.
9. Where applicable, inpatient facility charges for a newborn, where the mother is not a covered individual of the Plan, or where the baby's length of stay exceeds the discharge date of the mother, are subject to the co-payments, deductible, and coinsurance shown in the Schedule of Benefits.
10. This pertains to certain services such as CT Scans, MRI's, PET Scans, Bone Mineral Density Testing and Nuclear Scans. Please contact the Carpenters' Benefit Office for a complete list of diagnostic services that apply.

Article III

MEDICAL BENEFITS

How to Use the Plan

Generally

The medical plan offers you and your eligible dependents financial protection against a wide range of health care expenses resulting from non-occupational sickness or injury.

This Plan has entered into agreements with two different networks of medical care providers. Under these agreements, medical care providers (doctors, hospitals, etc.) who are members of the networks have agreed to charge specified fees for their services and in most cases, these fees are lower than their normal fees. The **In-Network** is the local network of providers with which the Plan has an agreement. The **Out-of-Area Network** is the network of providers *outside the local area* with which the Plan has an agreement.

To receive the highest level of benefits, you must receive care from an In-Network Provider. Although you may go to any physician, hospital or other provider you choose for medical care, you will receive the highest level of reimbursement from the Plan when you use In-Network Providers. The Fund Office has provided you with a directory of In-Network Providers. You can also check the Network's website for a list of Providers.

If you receive care from a provider that is not located within the In-Network service area, your eligible expenses will be considered under either the **Out-of Area Network** or the **Non-Network** benefit level. For a complete definition of the In-Network service area, see Appendix F.

In-Network Benefit Level

There are no deductibles for In-Network benefits. After a small co-payment for some services, the Plan pays 100% of covered expenses (except with respect to mental health and substance abuse treatments). You are not required to choose a primary care physician or receive any referral in order to receive In-Network benefits. You simply have to receive care from a participating In-Network Provider and, in some cases, receive prior authorization in order to receive the highest benefits. See page 23 under Managed Care for more complete information on services that require prior authorization.

Out-Of-Area Network And Non-Network Benefit Level

If you travel or reside outside the In-Network service area, you have the option of seeking treatment from an Out-of-Area Network provider or from a Non-Network provider. You must pay an annual deductible with such providers. After the deductible is satisfied, the Plan pays its coinsurance (generally 90% for the Out-of-Area Network Providers and 70% for Non-Network Providers), and you pay yours (generally 10% for the Out-of-Area Network Providers and 30% for Non-Network Providers). For Out-of-Area Network Providers, the Plan's coinsurance rate is applied to the contracted charge between the Network and the provider, so your out-of-pocket amount is usually lower.

The Co-Payment

As shown in the Schedule of Benefits, certain services require you to pay a small co-payment. **"Co-payment" means the fixed dollar amount that you pay for physician's office visits and for other services**. Most providers expect to collect the co-payment at the time the services are provided. Co-payment amounts are not counted toward satisfying the annual deductibles, and are due whether or not the deductible has been met.

The Deductible

Annual Individual Deductible

You do not have to pay a deductible for In-Network benefits. However, for Out-of-Area Network Provider and Non-Network Provider charges, the deductible amount is the initial amount of covered expenses that must be incurred in a calendar year before you or your dependents are eligible to receive benefits from the Plan. The deductible applies to the covered expenses incurred by each person during one calendar year.

Charges by providers participating in the Out-of-Area Network are subject to the calendar year deductible specified in the Schedule of Benefits for Out-of-Area Network Providers. Charges by all Non-Network providers are subject to the calendar year deductible amount specified in the Schedule of Benefits for Non-Network Providers.

Any covered charges applied to one part of the deductible will also count toward satisfying the other part. For example, if you have satisfied the Out-of-Area Network deductible, your deductible for Non-Network expenses will be reduced by that amount.

Co-payment amounts do not count toward deductible.

Annual Family Deductible Limit

If, in one calendar year, the covered charges incurred and applied to the individual deductibles for all covered family members combined reaches the Family Deductible Limit shown in the Schedule of Benefits for Out-of-Area Network Providers, then no additional deductible will be required for Out-of-Area Network provider charges incurred by any covered family member for that calendar year.

If, in one calendar year, the covered charges incurred and applied to the individual deductibles for all covered family members combined reaches the Family Deductible Limit shown in the Schedule of Benefits for Non-Network Providers, then no additional deductible will be required for any covered charges incurred by your covered family members for that calendar year.

Out-of-Pocket Maximum

This feature of your medical coverage helps to limit the amount you are required to pay for covered medical expenses incurred during one calendar year.

For most covered expenses, the Plan pays the applicable coinsurance percentage shown in the Schedule of Benefits, after any applicable deductible and co-payment is satisfied. If, in one calendar year, the amount of the deductible and coinsurance payments made by a covered individual reaches the Annual Out-of-Pocket Limit shown in the Schedule of Benefits, the Plan will pay 100% of any additional covered expenses, as long as they are incurred by the same person, within the same calendar year.

Like the deductible, any covered charges applied to any part of the out-of-pocket limit will also count toward satisfying the other parts. For example, after you have satisfied the Out-of-Area Network out-of-pocket limit for Out-of-Area Network charges, your out-of-pocket for Non-Network expenses will be reduced by that amount.

The out-of-pocket maximum feature does not apply to amounts you must pay for the following:

- Ineligible charges;
- Co-payment amounts;
- Prescription drug charges or prescription co-payments;
- Benefit reductions caused by failure to comply with the Medical Care Management Company or Managed Mental Health Care programs;
- Charges for treatment of mental or nervous disorders, alcoholism or drug dependency; or
- Charges in excess of Plan maximums.

LIFETIME MAXIMUM PLAN BENEFIT

In-Network and Out-of-Area Network

The maximum lifetime benefit for each covered individual is $2,000,000. In-Network and Out-of-Area Network provider charges are eligible for up to $2,000,000 in benefits dollars paid per lifetime.

Out-of-Network and Medicare Supplement

Out-of Network or Medicare Supplement Plan provider charges paid are eligible for up to $1,000,000 per lifetime. Lifetime maximum charges cross accumulate with charges paid under the In-Network or Out-of-Area Lifetime maximums.

REASONABLE AND CUSTOMARY CHARGES

Only that part of a charge for a covered service or supply that is reasonable and customary is eligible under the Plan. Generally speaking, a charge by your physician or by any other provider of services or supplies is considered reasonable and customary if it does not exceed the prevailing charge for the same or similar service or supply made by others of similar professional standing in the same geographic area.

The Plan applies industry practices and standards in determining reasonable and customary charges. The prevailing charge level for Non-Network providers is determined for physician's services using information about fees actually charged in the area. For example, if 90% of the physicians in the area usually charge $150 (or less) for a given type of surgical operation, then $150 would be considered the prevailing charge level in that area for that particular surgical operation. For injectable medications, the prevailing charge is

determined to be the average wholesale price. For multiple procedures such as surgery or anesthesia, the reasonable and customary limit is determined in the usual way for the first procedure, and a percentage reduction is applied to the remaining procedures.

If your Non-Network provider charges in excess of the reasonable and customary charge as determined by the Plan, you will be responsible for paying the difference.

In-Network and Out-of-Area Network providers have agreed to accept pre-negotiated fees for each service as the maximum eligible for reimbursement by the Plan. Therefore, you are not responsible to pay the difference between the provider's usual charge and the Network pre-negotiated fee for each covered service.

BENEFITS PAID BY THE PLAN

Generally

As previously indicated, the amount of benefits you will receive from the Plan depends on whether care is received from In-Network, Out-of-Area Network, or Non-Network Providers. In general, subject to all other provisions of this Plan, medical benefits are payable for covered charges, after the applicable co-payment and deductible, at the coinsurance rate shown in the Schedule of Benefits.

Medical Necessity

Except for the routine care and preventive care benefits expressly described in this booklet, the Plan does not pay any benefits for services or supplies that are not medically necessary, as defined in Appendix D.

Special Rules for Certain Benefits

Certain types of medical expenses are considered differently or have additional requirements, as explained in the following sections. Also, see the Managed Care rules that start on page 23 and special rules that apply to mental and nervous disorders and substance abuse that start on page 26.

Routine Mammography

The deductible will be waived and benefits payable at 100%, up to the maximum benefit specified in the Schedule of Benefits, for a routine mammography screening and accompanying radiologists' interpretation according to the following schedule:

- For a female age 35 through 39, benefits will be payable for one mammogram.
- For a female age 40 or older, benefits will be payable for one mammogram per year.

For a female under age 35 who is considered a high-risk case, benefits will be payable for mammograms prescribed by a physician according to generally accepted medical practice. A "high-risk" case includes:

- A family history of breast cancer (i.e., mother or sister);
- An indication of cancer from a breast biopsy;
- The first child after age 30;
- No children by age 30;
- Obesity.

Routine In-Hospital Well-Baby Care

The following routine in-hospital well-baby care expenses are considered Covered Charges by the Plan:

- Hospital charges for nursery care.
- Hospital charges for other services and supplies while confined.
- Physician's charges for visits during hospital confinement.

Where applicable, inpatient facility charges for a newborn, where the mother is not a covered individual of the Plan, or where the baby's length of stay exceeds the discharge date of the mother, are subject to the co-payments, deductible, and coinsurance shown in the Schedule of Benefits.

Preventive Care

Benefits are payable as shown in the Schedule of Benefits, after the co-payment, for routine physicals, diagnostic tests, immunizations, pap smears and prostate screenings performed in your In-Network or Out-of-Area Network physician's office. If such services are performed by a Non-Network Provider, they are paid at the lower co-insurance rate shown in Schedule of Benefits and are subject to the Non-Network Deductible.

If you have eligible preventive care services performed outside of your physician's office, or that are not performed at an In-Network provider's lab, benefits are payable at a lower coinsurance as shown in the Schedule of Benefits.

Regardless of whether the service is performed by an In-Network, Out-of-Area Network, or Non-Network provider, benefits for preventive health services for each covered individual are limited to the maximum annual benefit shown in the Schedule of Benefits.

Emergency Room Visits

In the event that you require the services of an emergency room, the Plan will provide benefits as shown in the Schedule of Benefits, after payment of the applicable co-payment. If you are admitted to the hospital directly through the emergency room, the emergency room co-payment will not apply and benefits are payable at the appropriate coinsurance, after satisfaction of the admission co-payment and any required deductible.

It is important to keep in mind that emergency room benefits are payable only for true emergencies. An "emergency" is defined as a serious medical condition that arises suddenly and requires immediate care and treatment to avoid serious jeopardy of your or your dependent's health. ***No benefits are payable for non-emergency services received in the emergency room.***

Ambulance Services

Medically necessary ambulance services are payable as shown in the Schedule of Benefits, regardless of the provider or hospital. Additional limitations on ambulance services are shown under Covered Charges beginning on page 30.

Pregnancy

Necessary treatment of pregnancy is covered on the same basis as any other sickness or injury for covered members and covered dependent spouses (elective abortions are not covered). All the provisions and limitations of the Plan, including Managed Care, also apply to pregnancy. It is recommended that you or your physician notify the Medical Care Management Company of your pregnancy in the first trimester in order to be properly enrolled in the prenatal program discussed on page 25.

Keep in mind that, under Federal law, a group health plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing these lengths of stay. However, nothing in the law prevents the mother or her newborn child from being discharged earlier than 48 or 96 hours if both the mother and attending physician agree to the discharge.

If confinement beyond 48 or 96 hours is required, you and/or your physician must follow the Managed Care Requirements beginning on page 23.

No benefits are payable for the pregnancy of a covered dependent child.

Post-Mastectomy Charges

The Plan covers expenses incurred for medically necessary mastectomies including reconstruction of the breast(s) removed. In addition, under Federal law, coverage must also be provided for the following services in connection with a covered mastectomy, if you and your attending physician determine they are medically necessary:

- Surgery and reconstruction of a remaining breast to provide a symmetrical appearance,
- Prostheses, and
- Physical complications in all stages of the mastectomy, including lymphedemas.

Benefits for these expenses are payable as for any other covered expense of the Plan and benefit levels will be based on the provider rendering the service.

MANAGED CARE

Generally

Under the Managed Care program, a team of medical professionals reviews hospitalizations and many other types of services to determine the medical necessity of the care and the availability of other, more cost-effective resources. It is intended to help you become a better, more-informed consumer of health care and to help you receive the most appropriate care for your condition.

In order for you to receive the maximum allowable benefits under the medical plan, the following services must be certified in advance:

- All hospital admissions, except certain maternity admissions (see below).
- All admissions to Skilled Nursing Facilities or Inpatient Specialty care programs such as Rehabilitation and Hospice.
- All pregnancy related services including, but not limited to: Global obstetrical care, perinatologist visits, and ultrasounds in excess of three (3). For maternity admissions, the Medical Care Management Company should be contacted in the first trimester of pregnancy after the first physician office visit, and again after admission to the hospital for delivery. **Note:** Under Federal law, your physician is not required to obtain authorization from the Plan for a maternity stay that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section.
- All Hospital/facility observation stays (including obstetrical care).
- All surgical procedures performed at a hospital, outpatient or surgical center with the exception of: tubal ligation, tonsillectomy, adenoidectomy, and myringotomy tubes. Surgical procedures performed in the physician's office do not require prior authorization.
- All transplants must be pre-certified by the Medical Care Management Company and you must give notification to the Carpenters' Fund Office.
- Ambulatory (outpatient) procedures, specified on page 25.
- Ancillary services, specified on page 25

It is important that you discuss this provision with your physician so that you both understand what is to occur. **Failure to comply may result in reduced benefits.**

You may reach the Medical Care Management Company by dialing the toll-free number shown on your medical plan I.D. card. The Fund Office can also provide additional information on the Medical Care Management Company.

These Managed Care provisions do not apply to mental health and substance abuse conditions. Special pre-certification rules apply to treatment of those conditions. (Refer to page 26 for information on this subject).

Hospitalizations

How to Request Pre-admission Certification

If you are admitted by an In-Network Physician to the hospital, he or she is responsible for obtaining Pre-admission Certification for you. If you are admitted by an Out-of-Area Network provider or a Non-Network provider, you have ultimate responsibility to ensure proper pre-certification is obtained.

The procedures for pre-admission certification are as follows:

- You or the attending physician must call the Medical Care Management Company at least 72 hours before a scheduled admission.
- For emergency admissions, the covered individual, his or her physician or a family member must contact the Medical Care Management Company by telephone within the next business day. See definition of "emergency" in Appendix D.

The Medical Care Management Company will determine whether the proposed hospitalization is certified.

A hospitalization that is certified will be assigned an initial length of stay, during which benefits will be payable if authorized by the Plan, based on the covered individual's specific situation and the nationally developed norms for that treatment.

Pre-admission certification only confirms that the requirement of medical necessity has been satisfied for the proposed treatment. Pre-admission certification does not guarantee either coverage or benefits under the Plan. Benefits are subject to all the provisions and limitations of the Plan.

Continued Stay Review

If, after admission to the hospital, the attending physician indicates the covered individual requires an extended length of stay, the Medical Care Management Company will request additional information substantiating the continued inpatient hospital confinement. If additional days are certified, a new length of stay will be assigned. This procedure is followed until the covered individual is discharged from the hospital.

If determined by the Medical Care Management Company that continued hospitalization is not certified, the attending physician and the covered individual are notified immediately.

Pregnancy, Prenatal Care and the "Building Blocks" Program

To assist you in a safer pregnancy and delivery, you will be automatically enrolled in the "Building Blocks" prenatal program. The program is designed to provide expectant parents with a wide variety of free information and services. Specially trained nurses will work with you, your family and your physician to:

- assess your risk of pregnancy and delivery complications,
- answer your questions 24-hours a day,
- provide educational materials, and
- assist in the prevention of pregnancy-related complications.

To enroll in the program, your doctor should contact the Medical Care Management Company in the first trimester of pregnancy after the first physician office visit, or you may contact the Fund Office directly. The Fund Office will notify the "Building Blocks" program of your pregnancy. A prenatal nurse will contact you to explain the program and complete your enrollment. If you are compliant with the program and your doctor's treatment plan, the Plan will provide the following benefits:

- 100% of the negotiated cost for any ancillary services, such as home IV therapy, home uterine monitoring or other home care needs that are ordered by your physician and provided through the prenatal program.
- 100% of the negotiated cost for one home health visit after delivery to make sure all is well with you and the baby.

The "Building Blocks" prenatal program is now part of your benefit plan and provided at no cost to you. Again, it is essential that the Medical Managed Care Company or the Fund Office be notified of your pregnancy as soon as possible.

The "Building Blocks" prenatal program is not available to pregnant dependent children.

Ambulatory (Outpatient) Procedures and Ancillary Services Review

To receive the maximum benefits under the Plan, you, a family member or your physician must contact the Medical Care Management Company prior to receiving ***all surgical procedures at an outpatient or surgical center*** (except: tubal ligation, tonsillectomy, adenoidectomy and myringotomy tubes) or any of the following surgical and diagnostic procedures:

- Bone mineral density (all types)
- Surgical and Non-surgical TMJ Treatment
- PET scans
- Hysteroscopy
- All Cardiac Stress Imaging
- Sclerotherapy
- Cardiac Nuclear Scans
- MRI
- Pain management injections including epidural, facet and trigger point injection

You must also contact the Medical Care Management Company before any of the following ancillary services or supplies are provided:

- Cardiac/Pulmonary Rehabilitation
- Orthopedic devices
- Physical, Speech, or Occupational therapy
- Proton Beam Therapy
- Prosthetic devices
- Injectable medications
- Home health care
- Durable medical equipment
- Dialysis
- Genetic testing
- Hyperbaric treatments
- Brachytherapy
- Intensity modulated Radiotherapy

The Medical Care Management Company will review the proposed procedure and/or treatment plan. If your physician determines that you need extended ancillary services, the Medical Care Management Company will request additional information substantiating the continued treatment. If approved, the Medical Care Management Company will certify continued care. This procedure is followed until the care is no longer needed or approved. You and your physician or provider will be notified immediately if any procedure or service is not certified.

MEDICAL CARE MANAGEMENT

Medical care management is designed to help you in the event of a serious sickness or injury, including necessary organ transplants. Nurse case managers will work with you, your family, and your physician to ensure that the most appropriate and effective treatments are made available. Services include education, support, and coordination of services such as home health, medical equipment, skilled nursing and hospice.

Benefits under this medical care management provision are payable like any other covered expenses and will vary with the provider rendering the service. Your benefits under this provision are also limited to the patient's lifetime maximum benefit.

Medical care management is a free service offered to covered members. The nurse care managers will coordinate services with providers to limit your out-of-pocket expenses. Of course, you, your family and your physician make the final decisions about the patient's care.

How Your Benefits are Affected

If you do not follow the Managed Care procedures, and you receive your care from Out-of-Area Network providers or from Non-Network providers, your benefits will be affected. Even if the Plan ultimately determines that the services you received should be covered under the Plan, if you failed to comply with these managed care procedures, your benefits will be reduced as follows:

For non-emergency admissions: if you do not call the Medical Care Management Company before you or a family member is admitted to the hospital, benefits for each day of hospital confinement, prior to the time that the Managed Care Company is called, are reduced by 10%, not to exceed $1,000.

For emergency admissions: if you do not call the Medical Care Management Company by the end of the next business day following admission, benefits for each day of hospital confinement, prior to the time that the Medical Care Management Company is contacted, are reduced by 10%, not to exceed $1,000.

If you do not call the Medical Care Management Company prior to the performance of any surgical or diagnostic procedure or before receiving an ancillary procedure specified in a previous section, benefits for the physician or provider performing such service are generally reduced by 10%, not to exceed $1,000.

Determinations by the Medical Care Management Company are used for the sole purpose of determining whether medical necessity is satisfied as a requirement for benefits under this Plan, and are not intended as medical advice. You and your physician are ultimately responsible for deciding the appropriate course of medical treatment, regardless of how the decision may affect the benefits payable under the Plan.

NOTE: With the exception of certain services for which the Plan specifically states that no benefits are payable unless pre-authorization is obtained, your benefits otherwise payable for any one confinement, procedure or ancillary service will not be reduced more than $1,000 solely because of your failure to call the Medical Care Management Company when required by the foregoing Managed Care provisions. However, if you fail to get an advance determination of medical necessity by calling the Medical Care Management Company and it is later determined that your treatment was not medically necessary, no benefits will be paid. In addition, as explained in the following pages, some specific Plan benefits related to mental health and substance abuse are payable only if pre-authorized by the Mental Health Managed Care Company.

MENTAL OR NERVOUS DISORDERS/CHEMICAL AND DRUG DEPENDENCY

PRE-AUTHORIZATION IS REQUIRED

All treatment for mental and nervous disorders and chemical and drug dependency requires pre-certification from the Mental Health Managed Care Company, except in an emergency. The telephone number for the Mental Health Managed Care Company is shown on your ID card and at page 63 of this booklet.

The Mental Health Managed Care Company is a company that specializes in providing assessments, consultations and referrals to individuals seeking assistance with mental health and substance abuse problems. The Mental Health Managed Care Company network includes hospitals, residential and day treatment programs, and practitioners that meet the Mental Health Managed Care Company's membership and credentialing requirements, and agree to regular reviews to ensure they maintain quality standards.

In general, no benefits are payable for any expenses you incur for mental health and/or substance abuse treatment if you do not contact the Mental Health Managed Care Company prior to obtaining treatment. In addition, no benefits are payable for any mental health/substance abuse care that is not authorized in advance by the Mental Health Managed Care Company.

However, benefits are payable for emergency treatment rendered by a Mental Health Managed Care Company network hospital provider for an emergency medical condition without advance authorization. See definition of "emergency treatment" in Appendix D.

While emergency treatment does not require pre-authorization, the patient or a representative must notify the Mental Health Managed Care Company by telephone no later than the next business day following commencement of the emergency treatment.

MENTAL HEALTH AND SUBSTANCE ABUSE NETWORK

The Plan has an agreement with a Mental Health Managed Care Network under which Mental Health Network providers have agreed to charge agreed upon amounts for the treatment of individuals covered by this Plan. No benefits are provided for treatment of mental or nervous disorders or substance abuse unless such treatment is rendered by a provider that is in the Mental Health Managed Care Network. This network does not necessarily include the same providers that are included in the directory of medical In-Network Providers. Therefore, it is critical that you or your dependent contact the Mental Health Managed Care Company prior to seeking treatment for mental or nervous disorders or substance abuse. If you get treatment from a non-network provider, you will have to pay the full cost.

Benefits

Benefits for treatment of mental and nervous disorders are paid at the percentage shown in the Schedule of Benefits, after satisfaction of the annual deductible or co-payment as applicable, and are subject to the following limits:

- **Inpatient Care**
  Provided care is pre-authorized, the Plan pays benefits for necessary treatment of mental and nervous disorders, alcoholism and/or substance abuse while confined in a hospital, limited to the number of days shown in the Schedule of Benefits per calendar year.

- **Partial Hospitalization**
  Partial hospitalization is defined as a program, generally lasting at least 3½ hours or more per day, and administered by a hospital in lieu of inpatient hospital confinement for treatment of mental and nervous disorders and substance abuse. Provided care is pre-authorized, the Plan pays benefits for necessary partial hospitalization limited to the number of days shown in the Schedule of Benefits per calendar year.

  If you exhaust your partial hospitalization benefit but have not yet used some or all of your inpatient hospital days for that calendar year, you may substitute each unused day of inpatient hospitalization for two days of "partial hospitalization" or "day care."

- **Intensive Outpatient Care**
  Provided care is pre-authorized, the Plan pays benefits for necessary treatment of mental and nervous disorders, alcoholism and/or substance abuse on an outpatient basis and is limited to the number of days shown in the Schedule of Benefits per calendar year. Such care is generally 3½ hours or less and provided two to three times per week.

  If you exhaust your intensive outpatient benefit but have not yet used some or all of your inpatient hospital days for that calendar year, you may substitute each unused day of inpatient hospitalization for two days of outpatient care.

- **Residential Care**
  Provided care is pre-authorized, the Plan pays benefits for necessary treatment of mental and nervous disorders, alcoholism and/or substance abuse in a residential facility limited to the number of days shown in the Schedule of Benefits per calendar year. This method of treatment is used primarily for treatment of chemical dependency patients, children and adolescents. The treatment program requires 24-hour confinement in a non-acute treatment facility, and is generally more custodial in nature.

  If you exhaust your residential care benefit but have not yet used some or all of your inpatient hospital days for that calendar year, you may substitute each unused day of inpatient hospitalization for two days of residential care.

- **Individual and Group Therapy**
  Provided care is pre-authorized, coverage for necessary individual and group therapy provided in the practitioners' office for the treatment of a mental and nervous disorder, alcoholism or substance abuse are provided as shown in the Schedule of Benefits.

Out-of-Pocket Maximums Do Not Apply.

IMPORTANT NOTE: Your payments for treatment of mental and nervous disorders and chemical and drug dependency are not subject to an annual out-of-pocket maximum. Therefore, the Plan never pays 100% of the covered cost of such treatment. The Plan's benefits are always limited to the percentage of covered charges shown in the *Schedule of Benefits*.

MEMBER ASSISTANCE PROGRAM (MAP)

In addition to the benefits described above for the treatment of mental and nervous disorders, the Plan provides a Member Assistance Program (MAP) through its Mental Health Managed Care Company.

The MAP is a confidential counseling service provided free of charge by the Plan for you and your eligible dependents. Program counselors will help you to better understand the problems you face, work with you to resolve those problems or learn methods to successfully live with them. The MAP provides help in the following areas:

- Stress management
- Positive drug/alcohol test
- Alcoholism and chemical dependency
- Marital and family problems
- Parenting
- Legal problems
- Emotional problems such as depression, anxiety and grief
- Chronic or life-threatening illnesses
- Emotional issues relating to caring for aging relatives

These services are completely confidential. If it is determined that your problem cannot be treated within the MAP setting, you will be referred to a provider within the Mental Health Managed Care Network for additional services. If such a referral is necessary, the Plan will provide the benefits described above for the treatment of mental and nervous disorders and substance abuse.

PRESCRIPTION DRUG PROGRAM

Prescription drug benefits are provided through contracted Pharmacy Benefit Managers (PBM) for both retail and mail-order prescription drugs. The retail PBM provides access to a national network of pharmacies that dispense prescription drugs to plan participants at reduced rates. You can get a listing of participating pharmacies by contacting the Fund Office or by contacting the number or website shown on your prescription drug ID card. Information on the mail-order PBM can be obtained from the Fund Office.

Except in emergency situations, if you have your prescription filled at a non-participating retail or mail-order pharmacy, you will not receive any benefits under the Plan.

For purposes of these prescription drug benefits, emergency is defined as a condition that presents itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to place the individual's health in serious jeopardy. In this situation, you will need to pay the full cost of the medication, and then file a claim with the retail PBM for reimbursement. Claim filing procedures are discussed beginning on page 53.

RETAIL PRESCRIPTION DRUG CARD PROGRAM

Regardless of the provider who writes your prescription, participating retail pharmacies will provide up to a 90-day supply of covered prescription drugs after you pay a low co-insurance for generic drugs or a slightly higher co-insurance for single-source brand name drugs (see Appendix G regarding the Starter Program). However, if you or your physician select a multi-source brand name drug (a brand name drug with a generic equivalent), you will be required to pay the difference between the cost of the Brand drug and the Generic equivalent, plus the Generic co-insurance.

In rare circumstances, your physician may determine that a generic drug is not medically appropriate for you. In this situation, your physician must submit proof of medical necessity for the multi-source brand name drug to the retail PBM for authorization. If approved, you may receive the multi-source brand name drug for the single-source brand name co-payment.

MAIL-ORDER PRESCRIPTION PROGRAM

You should use the mail-order program for maintenance prescription drugs. Maintenance drugs include those you take for periods of 30 days or longer for chronic health conditions, such as diabetes, asthma, arthritis, high blood pressure and heart disease.

However, when prescribed a new medication, you must make sure the medication is right for you. Before obtaining a 90-day supply, you will get a 30-day supply to try first. Once you know the new medication works for you and will be taken on an ongoing basis, you may order your prescription through the mail and obtain a 90-day supply.

To use the mail-order program, you will need to complete an order form and send it, together with your original prescription, for up to a 90-day supply and your generic drug co-payment or brand-name co-payment (contact your mail-order prescription provider for correct dollar amount), to the address printed on

the form. You should allow 14 days from the date that you mail your order for delivery. The form explains how to pay by credit card. Claim forms are available from the Fund Office.

As with the retail prescription drug program, if a brand name drug is dispensed when a generic drug is available, you will be required to pay the difference between the cost of the Brand drug and the Generic equivalent, plus the Generic co-insurance.

As with the retail program, in rare circumstances, your physician may determine that a generic drug is not medically appropriate for you. In this situation, your physician must submit proof of medical necessity for the multi-source brand name drug to the retail PBM for authorization. The retail PBM will notify the mail-order PBM of the determination. If approved, you may receive the multi-source brand name drug for the single-source brand name co-payment.

You may contact the mail-order pharmacy at the number shown on the form to check on your order, to verify the correct co-payment for your prescription drug and to answer any other questions you may have on the program.

Prescription Drug Co-Payments

You Receive:	You Pay: Retail	You Pay: Mail
Generic Drug	20%	20%
Brand (Single Source: No Generic Available)	30%	30%
Maximum Co-pay Per Script (Does Not Apply to Multi-source Brands)*	$50 for up to 30-day supply $100 for 31-90 day supply	
Annual Family Out-of-Pocket Maximum**	$2,500 Combined	
Days Supply	Up to 90	Up to 90
Generic Incentive (Brand Penalty when Multi-Source Brand Drug is selected over Generic Drug without medical reason)	Difference in cost plus generic co-pay	Difference in cost generic co-pay

* **Multi-Source Brands (Difference in Cost):** When a Generic drug is available and a Brand-Name dispensed, the member pays the "Difference in Cost" of the Generic Drug and the Brand Name drug **plus** the 20% Generic co-pay.

** Members under the Carpenters' Medicare Supplement Plan have a $2,500 annual out-of-pocket (OOP) maximum ***per member*** plus catastrophic coverage member cost sharing when the OOP is reached. The catastrophic cost sharing is the greater or 5% or $2 for generics and $5 for brands.

COVERED DRUGS

Covered drugs include the following:

- Drugs requiring a prescription under applicable Federal and State law;
- Compound medications when at least one ingredient requires a legal prescription;
- Injectable insulin, insulin syringes and test strips;
- Contraceptives; and
- Prenatal vitamins.

Please keep in mind that dispensing limits may apply to your prescription, and prior authorization is required for certain medications. To learn whether your prescription requires prior authorization and/or to request prior authorization, you may contact either the retail PBM at the telephone number shown on your ID card or the Fund Office.

EXCLUDED DRUGS FOR THE RETAIL AND MAIL-ORDER PRESCRIPTION DRUG PROGRAMS

The Plan does not provide any benefits under either the retail or mail order prescription programs for the following:

- Therapeutic devices or appliances, support garments and other non-medical substances.
- Medications available over the counter.
- Immunization agents, biological serum, vaccines, biologicals.
- Implantable time-released medication (i.e., Norplant).
- Experimental or investigative drugs, including compounded medications for non-FDA approved use (see definition of "experimental or investigative" in Appendix D).

- Drugs you are eligible to receive without charge under any workers' compensation law, or any municipal, state or federal program.
- Rogaine, Renova or Propecia or any other medication for the treatment of hair loss.
- Zyban and other smoking cessation agents, including gum, patches and nasal spray including Nicorette, Habitrol, Nicoderm, Nicotrol, ProStep, etc.
- Weight loss medications including Meridia.
- Tri-Vi-Flor and other pediatric vitamins containing fluoride.
- Any dental products, including fluoride preparations and rinses such as Luride and Phos-Flur.
- Drugs used to enhance or improve fertility.
- Growth hormones, unless prior authorization is obtained.
- Anabolic steroids, including Anadrol, Oxandrin, and Winstrol.
- Refills before 90% of your retail prescription or 60% of your mail-order prescription has been used.
- Any drugs that are not listed as covered.

Please Note: The exclusions and limitations set out above in this chapter apply to prescription drugs. Please refer to **Appendix G** for a detailed description.

CHARGES COVERED UNDER THE MEDICAL BENEFIT

Subject to the exclusions and limitations set out beginning on page 33 and subject to any special conditions applicable to a particular service or supply, the Plan treats as covered charges the pre-negotiated or reasonable and customary charges incurred by a covered individual for the services and supplies in the following list, provided they are:

- Performed or prescribed by a licensed physician (as defined on page 81), and
- Required in connection with the medically necessary treatment of accidental bodily injury or sickness (or are indicated as specifically covered preventive care), as defined on page 80, and
- Pre-certified in accordance with the Plan's Medical Managed Care and Mental Health Managed Care Programs, if applicable.

COVERED CHARGES

Room and board and routine nursing service for confinement in a hospital except that, for private room accommodations that are not medically necessary, the amount of the charge exceeding the hospital's average semiprivate room rate will not be included as a covered charge.

1. Charges by a hospital for medical services and supplies.
2. Charges by an ambulatory surgical center.
3. Surgery charges made by a physician for surgical care.
4. The necessary services of an assistant surgeon who actively assists the physician in surgery when the type of surgery requires assistance according to generally accepted medical practice. Payment for assistant surgeons will be reduced from the primary surgeon's pre-negotiated or reasonable and customary rate, based on industry standard reductions.
5. Anesthesia charges made by a physician or qualified allied health professional for the administration of anesthesia.
6. Professional service charges for medical care and services made by a physician, allied health professional, physiotherapist, radiologist or pathologist, or by a laboratory for diagnostic and X-ray examinations.
7. Charges for treatment of mental or nervous conditions, chemical or substance abuse, if pre-authorized by the Mental Health Managed Care Company and subject to the special maximums and limitations shown in the Schedule of Benefits on page 19 of this booklet.
8. Fees of graduate registered nurses (RN) or licensed practical nurses (LPN) for skilled private duty nursing services if authorized in advance by the Medical Care Management Company.
9. Charges for X-ray or radioactive therapy.
10. Charges for elective sterilization.

11. Medically necessary local ambulance service to, but not from, the nearest hospital equipped to furnish special treatment for the injury or sickness.
12. Charges for a routine mammography screening and accompanying radiologists' interpretation, up to the maximum benefit specified in the Schedule of Benefits. Refer to page 22 for limitations.
13. Charges for routine physicals, diagnostic testing, immunizations, pap smears and prostate screenings up to the maximum annual benefit specified in the Schedule of Benefits.
14. Reasonable and customary charges for manipulations, physical therapy, x-ray and laboratory tests rendered by a licensed chiropractor acting within the scope of his or her license, subject to the maximums specified in the Schedule of Benefits per covered individual per visit and per calendar year.
15. Charges by a home health care agency, up to a maximum of 100 visits per calendar year, provided the home health care is authorized in advance by the Medical Care Management Company or the Large Case Management Department.

    Covered charges will include:

    - part-time or intermittent nursing care by or under the supervision of a registered nurse (RN),
    - part-time or intermittent home health aide services consisting primarily of caring for the patient (four hours of home health aide services will constitute one visit, and any portion of four hours constitutes one visit),
    - physical therapy, occupational therapy and speech therapy provided by a home health care agency, and
    - medical supplies, provided such supplies would be covered if the patient had been confined in the hospital.

    Any charges for skilled nursing visits, other than as described above, are payable only if specifically pre-authorized by the Medical Care Management Company.
16. Speech therapy, but only if authorized as medically appropriate in advance by the Medical Care Management Company and rendered by a licensed qualified speech therapist.
17. Physical therapy by a licensed qualified physical therapist, but only if authorized in advance by the Medical Care Management Company.
18. Occupational therapy, including work hardening programs, rendered by a licensed qualified occupational therapist, but only if authorized in advance under the Medical Care Management Company.
19. Cardiac rehabilitation for up to 12 weeks to restore health as much as possible through exercise and education. Cardiac rehabilitation must be authorized in advance by the Medical Care Management Company.
20. Dental care, limited to services or supplies required for treatment of an injury to the jaw or to sound teeth as a result of an accident provided treatment is received as soon as medically appropriate. A sound tooth is one that does not provide evidence of severe dental decay or disrepair prior to the date of the accident.
21. Charges by a skilled nursing facility for a confinement of up to 100 days. Covered charges include:
    - Room, board and general nursing care, and
    - Charges for medical services and supplies required for treatment that are provided by the facility and used while in the facility as a bed patient.
    - In order to be eligible to receive these benefits, the confinement must be authorized in advance by the Medical Managed Care Company, and
    - Confinements must be preceded by a covered hospitalization or skilled nursing facility confinement and be necessary for the care or treatment of the injury or sickness which was the cause of the preceding confinement.
    - Confinements of longer than 100 days may also be eligible for benefits provided the care is certified as medically necessary through the Medical Care Management Department and authorized by the Trustees. You or your provider must contact the Fund Office for review.
22. Charges for the following other services and supplies:
    - Surgical dressings and ostomy supplies.
    - Electronic heart pacemaker or other medically necessary implantables,
    - Casts, splints, trusses, braces and crutches.

- Blood pressure monitors, only when ordered by a physician for the purpose of monitoring blood pressure at least once daily.
- Custom-made foot orthotics, limited to a maximum of $1,000 per covered person per calendar year. Replacement orthotics are further limited to one per calendar year, except for medically necessary custom-made orthotics prescribed by a physician due to a change in the patient's physical condition.
- Up to two pairs of surgical stockings per prescription in a six-month period when prescribed by a physician for such conditions as thrombophlebitis or conditions resulting from surgery.
- Rental, up to the purchase price, of a wheelchair, hospital-type bed, or other durable medical equipment that is made and used only for therapeutic treatment of injury or sickness or to replace a body function that was lost or impaired due to an injury, disease or congenital abnormality. Refer to the definition of "durable medical equipment" in Appendix D. The purchase price of a single acquisition of durable medical equipment will be covered in cases where, due to the expected duration of use, the rental charge is expected to exceed the purchase price.
- Replacement equipment, including equipment requested due to technological advancement, will be covered only if the attending physician demonstrates that the new equipment is necessary due to a change in the patient's physical condition.
- Charges for the repair of durable medial equipment are covered when the medically appropriate repairs are more cost effective than a replacement of the durable medical equipment, provided the equipment was not misused or abused.
- Oxygen and the rental of equipment for its administration.
- Blood and blood plasma not replaced by or for the patient.
- Prosthetic devices for the initial replacement of a lost natural body part, provided device is certified as medically necessary by the Medical Managed Care Company. . The covered charge for an electronic prosthetic device will be limited to the charge otherwise allowable for a non-electronic mechanical prosthetic appliance designed to replace the same natural body part. The cost of a replacement prosthetic device, other than a breast prosthesis, will be a covered charge only when required by a physical change on the part of the patient. For breast prosthetics, coverage will be provided as determined necessary by the patient's physician.

23. Non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ), including evaluation, X-rays, removable non-orthodontic appliances, therapy, minor procedures for occlusal equilibration or adjustments, treatment of muscle spasms and injections into the temporomandibular joint. Expenses of orthodontic treatment of TMJ, and orthodontic appliances for such treatment are not covered under the medical benefits of this Plan. All services in connection with TMJ must be pre-approved by the Medical Care Management Company as a condition of benefits.
24. Surgical treatment of Temporomandibular Joint Dysfunction (TMJ), including malocclusion, protrusion or recession of the maxilla or mandible, maxillary hyperplasia, maxillary hypoplasia or genioplasty. All services in connection with TMJ must be pre-approved by the Medical Care Management Company as a condition of benefits.
25. Charges for a hospice care program for an individual with a life expectancy of six months or less, including:
    - Inpatient care rendered by an approved hospice facility when medically necessary, and
    - Outpatient care billed through a hospice agency for the following services:
    - Skilled nursing services,
    - Home health care services,
    - Medicines, drugs and medical supplies,
    - Homemaker services,
    - Bereavement counseling for the surviving family members during the six-month period following the covered individual's death, up to a maximum of $300. Additional services may be available under the Mental Health Member Assistance Plan (MAP).
    - Physical, respiratory and speech therapy, and
    - Dietary and nutritional assistance.
26. Nutritional Counseling in conjunction with treatment for diabetes, hyperlipidemia, morbid obesity, essential hypertension, hypertensive heart or renal disease, congestive heart failure or chronic renal failure. Nutritional counseling received in conjunction with any other diagnosis must be preauthorized in advance by the Medical Care Management Company.

EXCLUSIONS AND LIMITATIONS – MEDICAL BENEFIT

Benefits will not be payable under any of the medical care benefits provisions of this Plan for or in connection with:

1. Sickness or injury arising out of the course of any occupation or employment for compensation, profit or gain, or for which the covered individual is entitled to or receives benefits under any applicable Workers' Compensation Act, Occupational Disease policy or similar law (including settlement of a claim).
2. Expenses for nursing, speech therapy and physiotherapy rendered by a close relative or a person who resides with the covered individual.
3. Any charges you or your covered dependents are not, in absence of this coverage, legally obligated to pay, or that are furnished without charge, paid for through any governmental agency, unless specifically billed for by such agency as provided by law.
4. Voluntary abortion, except when carrying the fetus to term would directly endanger the life of the mother, or except and to the extent that medical complications have arisen from the abortion.
5. Treatment of Pregnancy of any individual covered under the Plan as a dependent child.
6. Care and treatment of the teeth, gums or alveolar process, or for dentures, appliances or supplies used in such care and treatment, except as specifically provided for under Covered Charges. No coverage is provided for surgery or treatment related to the wearing or fitting of dentures or dental implants (see Dental Care Benefits section beginning on page 36 of this booklet).
7. Eye refractions, eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses (except for the initial pair of eyeglasses or contact lens prescribed following cataract surgery), eye exercises or any surgery, medical care, services or supplies related to treatment of a refractive error. These services may be available under the vision program. (See Vision Benefits Section beginning on page 38 of this booklet).
8. Hearing aids or the fitting of hearing aids.
9. Injury or sickness resulting from any act or incident of war, whether declared or undeclared, insurrection or any atomic explosion or other release of nuclear energy (except only when being used solely for medical treatment of an injury or sickness), whether in peacetime or wartime and whether intended or accidental.
10. Charges for drugs except as provided through the Prescription Drug Program.
11. Over-the-counter medicines.
12. Charges for research studies or any treatment not reasonably necessary to the therapeutic treatment of a sickness or injury (except as provided under the wellness/preventive care benefits of this Plan).
13. Cosmetic or reconstructive procedures, and any related services or supplies which alter appearance but do not restore or improve impaired physical function, except when performed for the:
    - repair of defects resulting from an accident, provided the treatment is received within one year of the accident, or as soon as medically appropriate,
    - replacement of diseased tissue surgically removed, provided the service is provided within one year of the surgery or as soon as medically appropriate,
    - treatment of a birth defect in a child provided the treatment is administered as soon as medically appropriate,
    - in the case of a mastectomy covered by the Plan, reconstructive surgery and surgery on the unaffected breast to produce a symmetrical appearance.
14. Charges for marital or family counseling or encounter or self-improvement group therapy and for school-related behavioral problems. These types of services may be provided under the Member Assistance Plan (MAP). See page 28 of this booklet.
15. Experimental or investigative treatment or any treatment not recognized as generally accepted medical practice by the medical profession in the United States. Procedures in question for their experimental or investigative nature will be reviewed by appropriate members of the medical profession for recommendation. Final decisions regarding coverage will be at the sole discretion of the Trustees. See Appendix D for definition of "experimental or investigative."
16. Charges that exceed reasonable and customary charges. See page 21 for definition of "reasonable and customary."
17. Charges for any service or supply not medically necessary for the treatment of a sickness or injury, or any treatment that exceeds in scope, duration or intensity, that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment, except as specifically listed as a covered charge. See Appendix D for definition of "medically necessary."

18. Medical expenses incurred in connection with reversal of an elective surgical sterilization procedure.
19. Expenses incurred in connection with the surrogate pregnancy, of or for any person, or assisted reproductive technology or "ART." ART means any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or pronuclear state tubal transfer.
20. Charges by a doctor of chiropractic for manipulations, physical therapy, X-ray and laboratory tests in excess of the specified covered charges and maximums.
21. Services or supplies not specifically listed under Covered Charges, including but not limited to:
    - air conditioners, humidifiers, dehumidifiers, purifiers, tanning booths, etc.,
    - over-the-counter orthopedic or corrective shoes,
    - exercise equipment, or
    - personal comfort items.
22. Injury or sickness resulting from participation in, or as a consequence of having participated in, any criminal or illegal activity or enterprise.
23. Custodial care (services provided mainly to assist the patient in the activities of daily living), education or training. Refer to the definition of "custodial care" in Appendix D.
24. Educational or developmental therapy.
25. Medical care, services or supplies received as the 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 and subrogation provisions of this Plan.
26. Charges for your or your physician's time spent traveling or for missed appointments.
27. Charges to secure additional information, unless requested by the Health and Welfare Fund Office.
28. 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.
29. For nicotine gum, patches, or pills, smoking cessation programs and any other medication or therapy designed to treat tobacco addiction.
30. Charges for or in connection with transsexual surgery.
31. Charges that are over 12 months old when submitted for consideration by the Plan.
32. Home obstetrical delivery.
33. Hypnosis and acupuncture.
34. Naturopathic or holistic services.
35. Massage therapy or rolfing.
36. Transportation for delivery of home health care.
37. Expenses for an autopsy or post-mortem surgery.
38. Electrical continence aids, anal or urethral.
39. Wigs or hairpieces.
40. Personal comfort or service items for use during confinement in a hospital, including but not limited to a radio, television, telephone and guest meals.
41. Exercise programs that are not traditionally medical in nature, such as swimming, horseback riding, etc.
42. Expenses incurred for procedures intended primarily for weight loss, unless treatment is medically necessary due to morbid obesity. (Morbid obesity means being at least 100 pounds above normal body weight or having a BMI 30% above the top of the normal range). In no event will weight loss medications be covered under the Plan.
43. Expenses for personal blood storage or elective harvesting and storage of blood from you or a donor.
44. Expenses incurred for the treatment of an injury or sickness arising from service in the uniformed services of any country.
45. Ossatron Lithotripsy (extracorporeal shock wave therapy) for treatment of plantar fasciitis.

MEDICARE SUPPLEMENTAL COVERAGE

If Medicare is the primary payor of benefits for you or one of your dependents who is covered under this Plan, that person will receive Medicare Supplemental Coverage, rather than the normal benefits provided by the Plan. (See page 70 of Appendix B for rules for determining when Medicare is the primary payor). The Medicare Supplemental coverage provides benefits at the level shown below on the Medicare Supplement Schedule of Benefits, regardless of the provider used. Although you are free to use Network providers, there will be no difference in the benefit level if you use a Network provider.

Effective January 1, 2006, members under the Medicare Supplement Plan must be enrolled in Medicare Parts A and B.

SCHEDULE OF BENEFITS

MEDICAL

TYPE OF BENEFIT	COVERAGE LEVEL
Annual Deductible Individual Family	 $300 $600
Co-Insurance for all covered medical services	80%
Individual Out-of-Pocket Maximum (including deductible)	$2,000
Lifetime Maximum	$1,000,000
Ambulance Services	$50 co-payment
Hospital Emergency Room	$100 co-payment (Co-pay waived if admitted)

PRESCRIPTION DRUG

You Receive:	You Pay: Retail	You Pay: Mail
Generic Drug	20%	20%
Brand (Single Source: No Generic Available)	30%	30%
Maximum Co-pay Per Script (Does Not Apply to Multi-source Brands)	$50 for up to 30-day supply $100 for 31-90 day supply	
Annual ***Individual*** Out-of-Pocket Maximum	$2,500 Combined	
Days Supply	Up to 90	Up to 90
Generic Incentive (Brand Penalty when Multi-Source Brand Drug is selected over Generic Drug without medical reason)	Difference in cost plus generic co-pay*	Difference in cost generic co-pay*

In addition, there is no pre-certification requirement for any treatment under the Medicare Supplemental Coverage.

You or your dependent should submit claims to Medicare for consideration. After Medicare has paid, the provider's bill and the Medicare explanation of benefits must be submitted to this Plan for consideration. This Plan will generally pay the balance of the covered charges, after the satisfaction of the applicable individual or family deductible. The total benefit paid by Medicare and this Medicare Supplemental Coverage cannot exceed 100% of the allowable expenses. (See page 69 for definition of "allowable expense.")

The lifetime maximum benefit under this Medicare Supplemental Coverage is $1,000,000.00.

*__Difference in Cost:__ When a Multi-source Brand drug is purchased, he or she will pay the 20% coinsurance co-pay related to the available Generic drug based on the cost of the Generic medication **PLUS** the difference in the cost of the Generic and the Multi-source Brand drug. The Plan will pay the 80% of the cost of the Generic medication, just as if the patient purchased the Generic medication. In this way, the Plan allowed the patient to purchase the drug but without effecting the overall cost of the Plan's payout of Prescription Drugs. The Difference in Cost ***does not*** count toward Out-of-Pocket or co-payment maximum. Please **refer to Appendix G for additional information regarding Prescription Drug Coverage.**

ARTICLE IV

DENTAL CARE BENEFITS

SCHEDULE OF BENEFITS

Deductible	$25
Annual Benefit Maximum	$2,000
Lifetime Benefit Maximum for Orthodontia	$1,500

The dental plan is designed to help you maintain your own and your family's dental health by providing coverage for a wide range of dental expenses. The Plan encourages preventive and ongoing maintenance care, and also provides financial assistance in case you have large dental bills.

Dental care benefits are provided automatically to members eligible under the Active Classification and their eligible dependents. Dental care benefits are available as an optional coverage at additional premium to members eligible under the Non-Active Classification and their eligible dependents. The premium is established by the Trustees from time to time.

THE ANNUAL DEDUCTIBLE

The deductible is the amount of covered dental expenses you must pay each year before you receive dental benefits from the Plan. The deductible is the first $25 of covered expenses for preventive, basic and major care incurred in a calendar year. There is no deductible for orthodontic care.

BENEFITS PAID BY THE PLAN

Generally

Subject to all other provisions of this Plan, dental benefits are payable at 100% up to the maximum fee shown in the Dental Fee Schedule. The dental plan is not designed to cover all of your dental expenses. The Dental Fee Schedule is detailed in Appendix C.

Oral Surgery

The Plan will treat as covered expenses services related to the surgical removal of teeth performed at the physician's office. Surgeries where it is medically necessary to perform the services in an ambulatory surgical center or hospital must be pre-approved to determine appropriateness of care. Covered charges may also include related radiology, pathology and anesthesiology. These oral surgery charges will not count toward the annual maximum benefit.

Any portion of a charge that exceeds the fee schedule allowable is not covered by the Plan.

MAXIMUM BENEFIT

The maximum benefit for all covered dental services for each covered individual per calendar year is shown in the Schedule of Benefits. The maximum benefit for covered orthodontia expenses for each covered individual's lifetime is shown in the Schedule of Benefits.

Alternate Treatment Plans

Situations frequently arise where there are two or more possible methods of treating a particular dental condition. In these situations, the amount included as covered dental expenses will be limited to the reasonable and customary charges for services that are customarily employed nationwide in the treatment of that condition and recognized by the dental profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice, taking into account the total current oral condition of the covered individual.

Predetermination of Benefits

Whenever the charges of a dentist for a proposed course of treatment are expected to be $300 or more, a predetermination of benefits is advised. By using this procedure, you will have an advance estimate of what portion of the cost will be covered.

The dentist's treatment program is filed with the Fund Office for review before beginning the course of treatment. This treatment program details the condition of the patient's mouth, the dentist's proposed services and the charges for those services. The Fund Office will then determine whether the treatment and the related expenses are appropriate, and will notify you and your dentist of the estimated benefits payable based on the planned course of treatment. If a description of the procedures to be performed and an

estimate of the dentist's charges are not submitted in advance, benefits will be payable in accordance with the standard features of the Plan and may be less than you expect.

Predetermination of benefits is not intended to interfere with your relationship with your dentist. Rather, it is intended to provide useful information to you and your dentist. You are both informed, in advance of the treatment, of the estimated benefits payable for the proposed course of treatment and of the expenses that will remain your full responsibility.

Please note that benefits for treatment of TMJ disorders are payable only under the Medical Benefit provisions of the Plan, and only if pre-authorized.

EXCLUSIONS AND LIMITATIONS

No benefits are provided under these Dental Care Provisions for any of the following:

1. Charges for services not specified in the Dental Fee Schedule shown in Appendix C. However, if a charge for a particular service is not included in the Dental Fee Schedule, but the Schedule contains one or more services which, according to customary dental practices, are separately suitable for the dental care of that condition, then a charge will be considered to have been incurred for a service listed in the Schedule that would have produced a professionally satisfactory result.
2. Anything not furnished by a dentist, except X-rays ordered by a dentist and services by a licensed dental hygienist under the dentist's supervision.
3. Charges that are not reasonably necessary or customarily provided for the covered individual's dental condition. (See definition of "medical necessity" in Appendix D).
4. Services furnished by or for the U.S. government or any other government unless payment is legally required, or to the extent provided under any governmental program or law under which the individual is, or could be, covered.
5. Services due to an injury or sickness arising out of or in the course of any employment.
6. 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.
7. Duplication or replacement of lost or stolen appliances.
8. A portion of a charge for a service in excess of the fixed schedule amount detailed in Appendix C.
9. Any dental services to the extent that benefits are payable under the medical benefits of this Plan.
10. Charges for services or supplies that do not meet accepted standards or dental practice or that are experimental or investigative in nature. (See definition of "experimental or investigative" in Appendix D.)
11. Oral hygiene and dietary instruction or plaque control programs.
12. Failure to keep a scheduled appointment with the dentist.
13. Completion of claim forms.
14. Charges for personalization or characterization of dentures.
15. 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. Generally, cosmetic and reconstructive procedures alter appearance but do not restore or improve impaired physical function. Facings on crowns, or pontics, posterior to the second bicuspid will always be considered cosmetic.
16. Charges for medications, infection control or medical waste disposal.
17. Injury or sickness resulting from participation in, or as a consequence of having participated in, any criminal or illegal conduct or enterprise.
18. More than two routine examinations and cleanings per calendar year.
19. Treatment, 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 and subrogation provisions of this Plan.
20. Charges for the treatment of any sickness or injury arising from service in the uniformed services of any country.
21. Charges associated with dental implants are limited to the alternate treatment allowable (usually fixed bridge) that would be performed in place of the dental implant treatment.
22. Charges for fluoride or sealants are limited to dependents up to the 16th birthday.

ARTICLE V

VISION BENEFITS

SCHEDULE OF BENEFITS

SERVICE	FREQUENCY OF SERVICE	VSP PROVIDER	NON-VSP PROVIDER
Examination	12 months	$10 co-payment covered in full	Up to $38
Materials		$25 co-payment Covered in full	
Lenses, one pair	12 months		
▪ Single Vision			Up to $31
▪ Lined Bifocal			Up to $51
▪ Lined Trifocal			Up to $64
▪ Lenticular			Up to $80
▪ Polycardonate (for children and handicapped dependents)			Not covered
Frames	24 months	Covered up to $105	Up to $210
Contact Lenses, one pair	12 months		Up to $105
▪ Medically necessary		$25 co-payment	
▪ Elective		Up to $105	

BENEFITS PAID BY THE PLAN

The vision plan provides benefits at 100% of covered expenses after the appropriate co-payment for the services and supplies listed in the Schedule of Benefits if you use a VSP network provider. Otherwise, the Plan pays the amounts shown.

Vision benefits are provided automatically to members eligible under the Active Classification and their eligible dependents. Vision benefits are available as an optional coverage at additional premium to members eligible under the Non-Active Classification and their eligible dependents. The premium is established by the Trustees from time to time.

HOW TO USE THE PLAN

VSP Network Doctors

When you need an exam, contact a VSP network doctor and make an appointment. Visit vsp.com or call (800) 877-7195 to find a VSP network doctor close to your home or work. You can also obtain a listing of VSP doctors from the Fund Office. When you call, you will need to give the doctor your name and date of birth, your Social Security Number and the name of your group (Carpenters' Health and Welfare). The VSP doctor will verify your coverage and then provide you with covered services and eyewear. At the time of service, the doctor will indicate which frames are within the Plan's allowance for frames. Also, at the time of service you will be asked to pay any required co-payment.

Non-VSP Providers

You may receive your vision care services and eyewear from any licensed optometrist, ophthalmologist, or dispensing optician. If your provider does not participate in the VSP program, you will need to pay for the services and then file a claim with VSP for reimbursement. Benefits are limited to those shown in the Schedule of Benefits for Non-VSP Providers.

Special Rules for Contact Lenses

Benefits for contact lenses are shown in the Schedule of Benefits. These benefits include the contact lens evaluation fee, fitting costs and materials. Contacts will be considered "medically necessary" only in the following situations, **and** only if pre-authorized by VSP:

- Following cataract surgery.
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses.
- Certain conditions of Anisometropia (unequal refraction in the eyes).
- Keratoconus (corneal protrusion).

To obtain pre-authorization from VSP, call VSP Member Services at (800) 877-7195 or visit the VSP web site at vsp.com and click on Members and Future Members.

Low Vision Benefit

If you have severe visual problems that are not correctable with regular lenses, you may be eligible for the following low vision benefit. Regardless of the provider rendering the service, this benefit is available only if the service has been pre-authorized by VSP. To obtain pre-authorization from VSP, call VSP Member Services at (800) 877-7195 or visit the VSP web site at vsp.com and click on Members and Future Members. Covered services include:

- A complete low vision analysis that includes a comprehensive exam of visual functions and
- Low vision therapy as visually necessary and appropriate.

Regardless of whether a VSP or Non-VSP provider renders the service, a $10 co-payment applies to the exam, and benefits for low vision therapy are limited to 75% of the amount authorized by VSP. If you use a Non-VSP provider, your out-of-pocket costs will likely be higher since you will be required to pay the difference between provider's full charge and 75% of the amount authorized by VSP.

EXCLUSIONS AND LIMITATIONS

No benefits are provided for additional charges related to the following:

1. Blended lenses.
2. Oversize lenses.
3. Photochromic lenses, or tinted lenses except Pink #1 and Pink #2.
4. Progressive multi-focal lenses.
5. The coating of the lens or lenses.
6. Laminating of the lens or lenses.
7. Frames costing more than the Plan's allowance. (VSP provider will indicate which frames are fully covered by the Plan's allowance).
8. Optional cosmetic processes.
9. Ultraviolet protected lenses.
10. Orthoptics or vision training, and any associated supplemental testing.
11. Plano lenses (less than a ±.38 diopter power).
12. Two pair of glasses in lieu of bifocals.
13. Replacement of lenses and frames that are lost or broken, except at the normal intervals allowed by the Plan.
14. Medical or surgical treatment of the eyes.
15. Any eye exam or corrective eyewear required by an employer as a condition of employment.
16. Experimental or investigative treatments or materials. (See Appendix D for definition of "experimental or investigative.")
17. Drugs or medications.
18. Corrective vision treatments such as RK, PRK LASIK and Custom LASIK.
19. 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.

ARTICLE VI

WEEKLY ACCIDENT AND SICKNESS BENEFITS

SCHEDULE OF BENEFITS

BENEFIT	AMOUNT
Accident & Sickness (Weekly Indemnity)	$280 per week

AMOUNT PAID BY THE PLAN

You are eligible to receive the Weekly Accident and Sickness benefit shown in the Schedule of Benefits above when you become wholly and continuously disabled by a non-occupational accident or sickness that occurs while covered under the accident and sickness benefits of this Plan, provided you are under the direct care and attendance of a legally-qualified physician. For purposes of this benefit only, "Disabled" means that you are prevented, due solely to a sickness or injury, from engaging in any or all of the duties of your specific, customary occupation.

Benefits begin on the first day of an accident disability, on the eighth day of a sickness or on the first day of your hospital confinement or outpatient surgery. You continue to be eligible for weekly benefits for up to 26 weeks during one continuous period of disability, as long as you remain disabled and under the direct care of a legally-qualified physician who certifies that you continue to be disabled. The weekly benefit amount is shown in the Schedule of Benefits above. The benefit for each day of a partial week of disability is one-seventh of the weekly benefit.

Continuous or New Periods 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. **For purposes of the Weekly Accident and Sickness benefit, with respect to benefit determination for the Weekly Accident and Sickness benefits of this Plan, hours received and paid for as a result of picket duty (referred to as Picket Hours) will not qualify as credit hours.**

Exclusions

No benefits are payable:

- For any day of disability on which you are eligible for, or receiving, Worker's Compensation benefits, even if the occupational and non-occupational disabilities are unrelated.
- For disabilities resulting from any injury or sickness due to the act or omission of a third party, unless you have fully complied with the reimbursement and subrogation provisions of this Plan.

ARTICLE VII

LIFE INSURANCE AND SAFETY ENHANCEMENT BENEFITS

SCHEDULE OF LIFE INSURANCE BENEFITS

BENEFIT	AMOUNT
Group Life Insurance for eligible member	$8,000
Dependent Life Insurance for eligible dependents	$2,000
Accidental Death and Dismemberment Insurance (eligible members only)	$8,000

MEMBER LIFE INSURANCE

Amount

If you die from any cause while you are insured, the benefit amount shown on the above Schedule of Benefits will normally be paid in a lump sum to the beneficiary of record with the Fund Office. However, upon request, information will be furnished regarding several optional modes of settlement.

Total proceeds from all group life insurance benefits provided through the Carpenters' Health and Welfare Trust Fund on the life of any one member, either as an active member or under the extended life insurance provision, or both, shall in no event exceed the group life insurance amount specified in the Schedule of Benefits, except as may be due as earned interest in accordance with the practice of the respective insurance company.

Beneficiary

Your beneficiary will be:

- The person you designate in writing on the Fund's form for this purpose and will be recorded at the Fund Office.
- If more than one beneficiary is named, the proceeds will be shared equally unless you designate otherwise.

In the event the designated beneficiary on the Fund's form, at the time of your death, is your former spouse who was divorced or legally separated after the beneficiary designation was filed, any death benefit shall be paid as if the former spouse had predeceased you.

If any designated beneficiary predeceases you, that designated beneficiary's interest will end and all proceeds will be paid equally to the surviving designated beneficiaries.

In the event there is no surviving designated beneficiary or in the event there is no beneficiary designation on record with the Fund Office, the amount due will be paid as follows:

- To your spouse, if living.
- If your spouse is not living, to your surviving child or children, equally.
- If there are no surviving children, to your surviving parents, equally.
- If your parents do not survive you, to your estate.

You may designate or change your beneficiary at any time by filing a written request, on the Fund's form. Any designation or change will become effective upon receipt of satisfactory written notification at the Fund Office and the change will relate back and take effect as of the date you signed the form, whether or not you are living at the time of receipt of the request, but without prejudice to the 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.

EXTENDED LIFE INSURANCE (WAIVER OF PREMIUM)

If you become totally disabled before age 60 while insured and if your life insurance otherwise ends, the life insurance benefit in effect on the date coverage would otherwise end will be paid at death, provided you:

- remain continuously totally disabled,
- submit written due proof of the uninterrupted continuance of your total disability to the insurance company as follows:
    - The first of such proofs is received within 12 months after the date you cease active work. If you die during this 12-month period, the insurance company must receive proof not more than 12 months after the date of death.
    - Thereafter, when the insurance company requests proof of your continuing total disability.
- submit to medical examination by a physician selected by the insurance company whenever required by the insurance company,
- do not establish a claim under the conversion privilege, and
- surrender to the insurance company any policy of personal insurance issued on your life pursuant to the conversion privilege provision. The insurance company will refund premiums paid less any dividends or other indebtedness.

For purposes of this benefit, "totally disabled" means that because of a sickness or injury you cannot do the important duties of your job and cannot do the important duties of any other job for which you are fit by your education, training, or experience.

DEPENDENT LIFE INSURANCE

Eligible Dependents

The dependents who are covered under the life insurance policy are the same as your dependents who are covered under the Plan generally, except, life insurance benefits are not provided for:

- any dependents who live outside the United States or Canada;
- a stillborn or unborn child;
- an adult disabled child who was not covered on the day before the child reached the applicable age limit.

No person can be covered as the dependent of more than one member.

Dependent Benefits

If any of your eligible dependents die while covered, the amount of dependent life coverage shown in the Life Insurance Schedule of Benefits will be paid to you, if surviving at the death of the dependent. 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.

Life Insurance Conversion Privilege (Members and Dependents)

If your own or your dependent's insurance under the Plan ends because you are no longer eligible to participate in the Plan, you may arrange to continue your or your dependent's life insurance under an individual policy by making application to the insurance company.

The individual life insurance policy will be issued without medical examination and on one of the forms of policies then being issued by the insurance company but without disability or any other additional benefits.

Application for the individual policy must be made within 31 days of the date insurance coverage ends. If death occurs within 31 days following termination of insurance, a death benefit will be paid to your or your dependent's beneficiary in an amount equal to that which you or your dependent were entitled to convert, whether or not application had been made.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE (MEMBER ONLY)

Benefit

If you die from any cause, your life insurance benefits will be paid to your beneficiary. The AD&D feature of the Plan provides additional benefits if you die or are injured as a result of an accident.

Your AD&D benefit amount is shown in the Schedule of Benefits on page 41.

If you are injured in an accident, the AD&D feature of your coverage will pay a portion of your total benefit, depending on the type of injury. This schedule shows the percentage of your AD&D amount that is payable.

FOR LOSS OF:	THE PLAN PAYS:
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. Only one of the amounts, the largest, is payable for all losses resulting from one accident.

Losses must be the direct result of an accident and occur within 90 days after the accident in order for you to be eligible to receive these benefits.

Limitations on AD&D Benefits

No payment is made for losses caused or contributed by:

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

It is important to note life insurance and AD&D Benefits are not offered to those members and dependents under the Non-Active Classification who are covered under the Reinstatement provisions of this Plan.

Life Insurance Certificate Controls

The certificate of insurance issued by the insurance company controls the benefits provided by that company. In the event of any discrepancy between the summary provided here and that certificate, the provisions of that certificate will prevail. You may obtain a complete copy of the certificate by contacting the Fund Office.

SAFETY ENHANCEMENT BENEFITS

Eligibility

The persons eligible for safety enhancement benefits under this Article VII are:

- All employees covered by a collective bargaining agreement between an employer and the Carpenters' District Council of Greater St. Louis and Vicinity;
- Employees of the Carpenters' District Council of Greater St. Louis and Vicinity; and
- Employees of the Carpenters' Benefit Fund Office,

regardless of whether such employees have earned eligibility for other benefits under Article I.

Safety Training

The Plan will provide without charge, to all persons eligible under this Article, the safety training course known as the "OSHA 10-Hour Course," and any other safety training course approved from time to time by the Trustees as a benefit under this Article.

Substance Abuse Testing

The Plan will provide without charge, to all persons eligible under this Article, 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.

ARTICLE VIII

MULTIPLE COVERAGE LIMITATIONS

COORDINATION OF BENEFITS WITH OTHER MEDICAL PLANS

Like most group health plans, your medical, prescription drug, dental and vision benefits include a coordination of benefits (COB) provision. If you or a dependent is eligible to receive benefits under more than one medical plan, including no-fault automobile insurance plans, your benefits will be coordinated so that the total amount paid by all plans will not exceed 100% of the allowable expenses (defined in Appendix B) incurred.

Determining Which Plan is Primary and Which Plan is Secondary

Generally

Under COB, one plan is considered "primary" and the other "secondary." The plan that is primary pays first, and usually pays full regular benefits. The primary plan is determined as follows:

- Any plan that does not contain a coordination of benefits provision is primary.
- If a plan covers the patient as a member (or an employee), that plan is primary to the plan that covers the patient as a dependent.
- If the patient is a dependent child whose parents are married and not divorced or legally separated, the plan of the parent whose birthday is earlier in the calendar year is primary.
- If the patient is a dependent child whose parents are divorced, legally separated, or unmarried, the following rules apply:
    - A plan is primary if it covers a child as a dependent of a parent who by court decree must provide health coverage.
    - Where there is no court decree that requires a parent to provide health coverage to a dependent child, the plan of the parent who has sole physical custody of the child is primary. (The plan of the custodial parent's spouse is secondary and the plan of the other natural parent is third.)
    - Where there is a court decree that states that the parents shall share joint physical custody without stating that one of the parents is responsible for the expenses of the child, the plan of the parent whose birthday is earlier in the calendar year is primary.
- If a plan covers a person as an active employee, including extended coverage earned while an active employee, that plan is primary, and any plan that covers that person only as a retired or disabled member (or employee) is secondary. If a plan covers a person as a dependent of an active member (or employee), that plan is primary, and any plan that covers that person as a dependent of a retired or disabled member (or employee) is secondary.
- If a plan covers a person because of federal or state continuation of coverage laws, that plan is secondary to a plan that covers the person on any other basis.
- If the above rules do not apply, the plan that has covered the individual the longest period of time is primary.

After the primary plan pays its benefits, the secondary plan will, in most cases, pay the balance of your eligible medical expenses. However, no plan will pay more than it would otherwise pay in the absence of this provision.

To ensure you and your dependents receive the benefits to which you are entitled under both plans, it is important to make sure that the Fund Office has a current and complete Enrollment/Change Form on file. This form must be completed every time the other coverage changes. You can obtain an Enrollment/Change Form from the Fund Office.

It is also important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under his or her plan first. After you have received payment from that plan, then you can submit for payment to the Fund Office. When you submit a claim to the second plan, be sure to include the explanation of benefits from the primary plan, as well as another copy of the itemized bill. ***Remember, if you coordinate your benefits correctly, you will receive payment faster and still have the advantage of coordinated coverage under both plans.***

When Both Husband and Wife are Employed

If you and your spouse are both covered under this plan, the Plan will coordinate benefits. However, the Plan will never pay more than 100% of the covered charges incurred.

Apprenticeship Training School Employees

If you are an employee of the Apprenticeship Training School, are part of the Special Class Enrollment, and covered as a participant under this Plan, the Plan will coordinate benefits for medical benefits. However, the Plan will never pay more than 100% of the allowable expense.

Coordination with Medicare

Primary Coverage for Medicare-Eligible Active Members and Dependents

The Health and Welfare Plan assumes all actively working members and their eligible dependents will be provided with primary coverage under the Plan, with secondary coverage provided by Medicare. Before retirement, you should submit your claims to the Carpenters' Health and Welfare Plan first, then to Medicare. After retirement, you should submit the claim to Medicare first.

The Plan will be primary to Medicare for active employees who are eligible for Medicare on account of age, except that the Plan may elect to pay secondary to Medicare in the case of active employees who work for an employer defined as a small employer in the Medicare regulations.

For individuals first entitled to Medicare because of end-stage renal disease, the Plan will be secondary and Medicare will be primary after 30 months of coverage.

Effect of Medicare on Benefits for Retired Members

For retired members and their eligible dependents who have not elected coverage under the Plan-approved Medicare HMO, the Health and Welfare Plan provides benefits to supplement Medicare. Because you or any of your dependents are entitled to receive benefits under Medicare, your Health and Welfare Fund benefits will be reduced so the total amount paid by both plans will not exceed 100% of the allowable charges incurred.

When you receive the Medicare statement showing what Medicare has paid, you should submit a copy of the statement to the Fund Office, along with copies of your bills, covering the identical medical expenses. Expenses submitted may not be considered unless accompanied by a Medicare statement covering the same charges.

Information Rights

For the purposes of determining the applicability and implementation of the terms of this coordination of benefits provision of the Plan or any provision of similar purpose of any other plan, the Trustees may, without the consent of or notice to any person, release to, or obtain from, any insurance company or other organization or person any information that the Trustees deem to be necessary. Any person enrolled in this Plan automatically gives consent to this provision, and any person claiming benefits under this Plan agrees to furnish to the Trustees any information necessary to implement this provision.

Payment Adjustments

Whenever payments that should have been made under this Plan in accordance with this provision have been made by any other plan, the Trustees have the right, exercisable alone and in their sole discretion, to pay over to any organization making such other payments any amounts they determine to be warranted in order to satisfy the intent of this provision, 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.

Recovery Right

Whenever payments have been made by the Trustees with respect to allowable expenses in excess of the total amount of payment necessary at the time to satisfy the intent of this coordination of benefits provision, the Trustees have the right to recover such payments. The Trustees shall have the discretion to determine if an individual covered by this Plan must repay the Plan for an erroneous payment. Such payment shall be returned in a lump sum or deducted from future covered claims.

Complete COB Provisions

More detailed coordination of benefits provisions are contained in Appendix B.

Recovery from Third Parties – Subrogation and Reimbursement

The Plan is not obligated to pay any benefits on account of an injury or sickness of a person covered by the Plan (a "covered person") who receives payment from a third party on account of that injury or sickness. An example would be if a covered person is injured in an automobile accident, and receives a recovery from another driver or insurance company. If the Trustees determine, in their discretion, that there is a reasonable chance that a third party may be liable for an injury or sickness, then the Trustees have discretion either to withhold benefits until the third party's liability has been finally determined, or to advance benefits to the covered person before that time.

If the Plan advances benefits in such a situation, then the Plan is subrogated to the rights of the covered person, meaning that the Plan may (but is not obligated to) pursue and receive payment directly from the liable third party to recover the benefits paid. Alternatively, if the Plan advances benefits and the covered person receives a third-party recovery, the covered person is obligated to reimburse the Plan for the benefits paid.

The detailed terms and conditions of the Plan regarding your subrogation and reimbursement obligations are set forth in Part 2 of Appendix B. If you sustain an injury or sickness for which a third party may be responsible, you should review Appendix B carefully, and if you hire an attorney, you should ensure that your attorney is made aware of the provisions of Appendix B.

ARTICLE IX

OCCUPATIONAL ACCIDENTS OR SICKNESS

The Plan provides benefits for covered expenses incurred as a result of accidents or sicknesses arising off the job only, with the exception of the Life Insurance. Life Insurance benefits are payable in connection with either occupational or non-occupational deaths that occur while insured. No other benefits are payable on account of an injury or sickness sustained in the course of employment, or for which the covered person is entitled to or receives workers' compensation benefits.

Accidents or sicknesses arising from your employment should be reported immediately to your employer and processed under the Workers' Compensation Laws of the state in which the disability was incurred. If there is any question as to whether or not an accident or sickness occurring on the job is covered under the Workers' Compensation Laws, you should contact the nearest Division of Workers' Compensation Office, inquiring as to your rights under the laws.

ARTICLE X

ENROLLMENT, CLAIMS AND APPEALS

ENROLLMENT

As a pre-requisite and as a requirement for the filing of any claim for benefits, you must complete an Enrollment/Change Form. You must complete this form when you initially become eligible for benefits under the Plan and again for each "life-changing event" you have. Life changing events include marriage, legal separation, divorce, the birth or adoption of a child. You must also complete an Enrollment/Change form when you or one of your covered dependents becomes covered under another health plan (medical, dental, or vision, etc).

The Fund Office will require documentation, such as birth certificates and marriage licenses, as proof of the eligibility of your dependents. Further, the Fund Office may require you to provide copies of court documents, such as divorce decrees, needed to determine whether this Plan is the primary payor for a dependent.

You can obtain an Enrollment/Change form from the:

Carpenters Health and Welfare Fund Office
1419 Hampton Avenue
St. Louis, Missouri 63139
(314) 644-4802 or
(877) 232-3863 (Toll-Free)

TIME LIMIT FOR FILING CLAIMS

You must file a medical or dental claim within 90 days after services are rendered. If you do not furnish notice or proof within 90 days, your claim will still be considered if you show it was not reasonably possible to file the claim within that time and that the claim was filed as soon as reasonably possible.

However, the Plan will not under any circumstances, consider for payment claims for charges that were incurred, or a disability that began, more than 12 months prior to the date a claim is filed.

Filing Claims Generally

Definitions

For purposes of this Article X, the following definitions apply:

1. An "urgent care claim" is a claim for emergency treatment. (See definition of "Emergency Treatment" in Appendix D).
2. There are special very short time limits for deciding urgent care claims. This Plan is not subject to these special time limits because this Plan does not require pre-authorization of any emergency treatment. However, the Plan does require that a covered person or his doctor or family member notify the Plan's Medical Care Management Company or Mental Health Managed Care Company the next business day following the commencement of the emergency treatment. Failure to provide this notice to the Plan's Medical Care Management Company or Mental Health Managed Care Company will result in a reduction of benefits payable with respect to emergency treatment provided by an Out-of-Area Network Provider or a Non-Network Provider. See page 26 of this booklet.
3. A "pre-service claim" means any claim for medical care or treatment which, under the rules of the Plan, must be approved in advance of receiving treatment. Because all treatment (except urgent care treatment) of mental and nervous disorders and substance abuse must be authorized in advance by the Plan's Mental Health Managed Care Company, requests for such pre-authorization are "pre-service claims." There are also other services, treatments and supplies for which pre-authorization is required and which will therefore be treated as pre-service claims under this Plan. The descriptions of covered services in this booklet and the Managed Care provisions of this booklet identify the services, treatments and supplies for which pre-authorization is required. The Plan's time limits for deciding pre-service claims are shorter than the time limits for post service claims.
4. A "post service claim" means any claim that is not a pre-service claim as defined above.
5. An "adverse benefit determination" is any of the following: a denial, reduction, or termination of payments or a failure to pay part or all of a claim. An adverse benefit determination may be based on a number of factors, including but not limited to, a claim not covered by the Plan, the claimant's lack of eligibility, the experimental or investigational nature of the treatment, the application of the Plan's Managed Care provisions, or the lack of medical necessity for the treatment.

Miscellaneous Provisions Pertaining to Claims and Appeals

You may designate another person to act as your authorized representative for purposes of the Plan's claims and appeals procedures. To designate an authorized representative you will need to fill out a form which may be obtained from the Fund Office.

Under federal law the claimant has a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if dissatisfied with the decision of the trustees. Before bringing such an action the claimant must exhaust the Plan's claim and appeals procedure. Any such action against the Plan under ERISA must be filed within two years of the date on which the Trustees made their decision on appeal. Any such action against the insurance company must be filed no more than three years after the claim was due.

The Trustees may appoint an Appeals Committee to consider and decide appeals. Decisions made by the Appeals Committee shall have the same force and finality as decisions made by the full Board of Trustees.

The claimant further has the right to receive free of charge upon written request all documents, records and other information relevant to the claim. Such request should be sent to the Fund Office or the life insurance company.

Decisions on claims and appeals (with respect to benefits other than life and accidental death and dismemberment benefits) are uniformly made in accordance with the terms and conditions of the Plan documents and cannot be paid unless authorized by those documents. The decisions with respect to life and accidental death and dismemberment benefits are made uniformly in accordance with the insurance policy and cannot be paid unless authorized by that policy.

Important Note on Electronically Submitted Claims

The United States Department of Health and Human Services has issued federal regulations that require this Plan to accept claims via computer if a provider chooses to submit the claims electronically. (These regulations are located at 45 Code of Federal Regulations Parts 162 and are informally known as the Electronic Data Interchange (EDI) Rules.) These regulations also require that if a provider submits a claim electronically, that claim must be in a very specific electronic format. Finally, the regulations require that if the provider fails to use the very specific required electronic format, this Plan must reject the claim until it is submitted in the correct electronic format. For purposes of applying time limits within which this Plan must process claims for benefits, an electronically submitted claim will not be considered received by the Plan until it reaches the Plan's computer system (or the computer system of the Plan's agent) in the specific electronic format required by the above-referenced EDI Rules.

Examinations

The Plan reserves the right and opportunity to examine the person whose injury or sickness is the basis of a claim as often as it may reasonably be required throughout the course of the claim.

Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance

Requirements for Filing a Claim

If you or one of your covered dependents dies or you suffer a dismemberment, the appropriate claimant should give the Fund Office written notice of the loss. The Fund Office will provide a claim form and information about necessary documentation (i.e. death certificate, doctor's certificate). Send the notice to:

Carpenters Health and Welfare Fund Office
1419 Hampton Avenue
St. Louis, Missouri 63139
(314) 644-4802 or
(877) 232-3863 (Toll-Free)

The claimant should complete the claim form and submit it along with the required documentation to the Fund Office.

Time Limits for Filing a Claim

The claimant should provide the Fund Office with written notice of the loss within 20 days of the loss. Then the claimant should submit the claim form and other proof of loss to the Fund Office within 90 days. If the notice of loss or claim is late, the insurance company may still consider the claim if notice or proof was given as soon as possible.

Decision on the Claim for Life Insurance or AD&D Benefits

The Plan will initially determine whether the person whose death or dismemberment forms the basis of the claim was eligible for benefits under this Plan's rules regarding eligibility. If so, the Fund Office will forward the claim to the insurance company.

The insurance company will normally make a decision with respect to the merits of the claim within 90 days, and that 90 days can be extended by up to another 90 days. Should the insurance company determine such an extension is necessary, it will notify the claimant prior to the expiration of the initial 90 days. If the decision involved a disability determination, the insurance company will make a decision within 45 days. This 45-day period may also be extended. The insurance company will notify the claimant of the reason for any extension. If the extension is necessary because the claimant did not provide all necessary information the insurance company will indicate what information is necessary and give the claimant up to 45 days to provide it. While the insurance company is waiting for that information, its time limits stop running.

If the insurance company determines the claim is payable, it will issue a check to the appropriate payee and will forward it to the Fund Office, which will make note of pertinent information and then forward the check to the claimant.

Notice of Denial of Claim for Life Insurance or AD&D Benefits

If the insurance company or Plan denies the claim in whole or in part, the insurance company or Plan, as appropriate, will notify the claimant of the denial in writing which sets forth the following information:

- specific reason for the adverse benefit determination;
- reference to the specific plan or policy provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim;
- a description of the review procedures and time limits, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA; and
- if the decision involved a disability determination, a statement of any internal rule, guideline, protocol, or other criteria relied on and a statement of the claimant's right to obtain a free copy of it.

Appeal Procedures for Life Insurance and AD&D Claims

The claimant may appeal from a complete or partial denial of a claim by submitting a written request for review. Such a request must be submitted within 60 days after receipt of notice of the denial. If the denial involved a disability determination, the appeal must be submitted within 180 days.

If the notice of denial was made by the insurance company, the claimant should submit the appeal pursuant to the procedures set out by the insurance company in the notice of denial of the claim.

The insurance company will review the appeal and notify the claimant of its decision within 60 days. This 60-day period may be extended up to an additional 60 days. If an extension is necessary, the insurance company will notify the claimant.

If the appeal is from a claim involving a disability determination, the insurance company will decide the appeal within 45 days. This period may be extended up to another 45 days. If an extension is necessary, the insurance company will notify the claimant. If the extension is necessary because the claimant did not provide all necessary information, the insurance company will notify the claimant as to the information needed and give the claimant 45 days to provide it. The insurance company's time limits stop running while it is waiting for the information.

If the insurance company denies the appeal, the written notice to the claimant will state the reason for the denial, the specific policy provisions on which the denial was based, any voluntary appeal procedures, and a statement of the claimant's right to bring a civil action under ERISA. The insurance company will provide the claimant with free copies of documents, records and information relevant to the claim and appeal if the claimant makes a written request (including internal rules, guidelines or protocols with respect to a disability determination).

If the notice of denial was made by the Plan based on the Plan's eligibility provisions, the claimant should submit the appeal to:

Board of Trustees
% Benefit Plans Administrator
Carpenters Health and Welfare Plan
1419 Hampton Avenue
St. Louis, Missouri 63139

The claimant should state the reason he or she believes the denial was inappropriate and may include any comments, information, documents and records he or she believes relevant. The Trustees will consider all information and documents submitted and will not defer to the original decision.

The Board of Trustees will normally make a decision on the appeal within 60 days after they receive the appeal, but may extend this period for up to another 60 days. Should they determine such an extension is necessary, they will notify the claimant prior to the expiration of the original 60-day period.

Should the Trustees deny the appeal they will notify the claimant in writing. The notice will set forth the specific reasons for the denial, the Plan provisions upon which they relied and the same classes of information that was included in the initial notice advising the claim had been denied. The decision of the Trustees is final.

Claims Procedures for Weekly Accident and Sickness Benefits and Other Claims Involving Disability Determinations

Requirements for Filing a Claim

To file a claim for Weekly Accident and Sickness Benefits, the claimant (member) should submit a Weekly Accident and Sickness Form (Disability Form) to the Fund. Disability Forms can be obtained from the Fund Office in writing or in person at 1419 Hampton Avenue. St. Louis MO 63139 or may be requested by telephone toll-free at (877) 232-3863 or locally at (314) 644-4802.

Section I needs to be completed in its entirety by the member. Section II needs to be completed by the attending physician in its entirety. The completed Disability Form must be returned to the Fund Office. Please note that the attending physician should complete the Disability Form with an approximate date the member will be able to return to work. If the physician states, for example, "unknown" or "undetermined" or "present", benefits can only be considered payable through the date the physician signs the form. The Fund Office will then send a subsequent statement of claim form for additional disability. If the attending physician disables the member through a specific date and the member remains disabled beyond that date, the member may request a subsequent statement of claim form for additional disability. In lieu of this Disability Form, the member and the attending physician may furnish, in writing, all information contained on the Disability Form. The Plan may also require the member to be examined by a doctor of its choice.

Decision on Claim

Claims for Weekly Accident and Sickness Benefits will be processed promptly, but must be resolved at the initial level within 45 days of receipt by the Fund Office. The Plan may extend the decision-making period for up to an additional 30 days for reasons beyond the control of the Plan. For instance, additional information may be required from the member or attending physician in order to complete the claim. If, after extending the time period for a first 30-day period, the Plan determines it is still unable to make the decision within the extension period, it may extend the process for a second 30-day period. Department of Labor regulations require the Plan provide the disability claimant with an extension notice that details the specific reasons for the delay each time an extension is deemed necessary.

If an extension is necessary because the claimant needs to supply additional information, the claimant will have 45 days from receipt date of the extension notice within which to provide the required information. Failure to do so may result in denial of the claim or discontinuance of benefits payment.

If additional information is requested by the Plan for your claim, then the time for deciding your claim will be tolled (or stop running) until the earlier of the date on which the additional information is received or the expiration of the 45-day period for providing the additional information.

If any portion of a claim is not paid, or if a claimant does not understand or agree with the handling of a claim, there are several things to do. Most questions can be answered quickly and efficiently by either writing or calling the Fund Office at the address/phone number listed above. Address and telephone information is also listed on the Disability Form. If this does not resolve the matter, you may appeal.

Notification of Claim Denial

The member will be notified in writing if a claim has been denied in full or in part. The written denial will include:

- The specific reason for an adverse benefit determination;
- The specific Plan provision on which the denial was based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material is necessary;
- A statement regarding the right, upon request and free of charge, to access and to receive copies of documents, records and other information relevant to the claim for benefits;
- An explanation of the Plan's appeal procedures, including applicable time limits, and including a statement of the claimant's right to bring civil action following an adverse benefit determination on review;
- Information as to whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination and, if so, a statement that you can receive a free copy of the rule, guideline, protocol, or other criterion; and
- If the denial was based in whole or part on a medical judgment, a statement that an explanation of the medical judgment will be provided free of charge upon written request to the Fund Office.

Appeal Procedures for Weekly Accident and Sickness Benefits

After receiving notice of claim denial, the member or his/her authorized representative must submit a written request to the Board of Trustees for their review and final decision. Any request for review must be filed within 180 days of the date of the claim denial. A request for review of Weekly Accident and Sickness Benefits must be directed to:

Board of Trustees
% Benefit Plans Administrator
Carpenters Health and Welfare Plan
1419 Hampton Avenue
St. Louis, Missouri 63139

When requesting a review, the member of his/her authorized representative should state the reason they believe the claim denial was improper and submit any comments, documents, records or other information which is considered appropriate. The Trustees will consider all such submissions as part of the review. The member or his/her authorized representative may have reasonable access to, and copies of, all documents, records or other information relevant to the claim upon request free of charge.

As required by law, the Board of Trustees' claim review will not give deference to the original claim decision. If the original claim denial was the result of a medical judgment, the Plan will consult with a healthcare professional who has the appropriate training and experience to render an informed opinion. The healthcare professional will not be the one used for the original claim determination or his/her subordinate. Such individual or entity will be disclosed upon written request to the Board of Trustees.

The Board of Trustees, as fiduciaries of the Plan, will generally make a decision on the review within 45 days after receipt of the request for review, unless special circumstances require an extension of time for processing, in which case a decision will be made as soon as possible, but not later than 90 days after receipt of the request for review. If such an extension is required, a member of his/her authorized representative will be notified within 45 days after receipt of the request for review. If an extension is required because the Trustees have asked you for additional information, their time limits are tolled while they wait for that information.

Notice of the Trustees' decision to deny the appeal in whole or in part will be in writing and will include the specific reasons for the decision, as well as specific references to the pertinent Plan provisions on which the decision is based and other information of the type contained in the initial notice advising the member that the claim has been denied. The decision of the Trustees is final.

Other Claims Involving Disability Determinations

If the Plan's consideration of any benefit is based on a determination of an individual's disability, the same procedures and time limits that apply for weekly accident and sickness claims shall apply to such a claim and an appeal from denial of such a claim. For example, if the Plan denies your request to continue your coverage under the Non-Active Classification because the Plan determines you are not disabled, both the Plan and you must use these procedures and time limits for dealing with that claim and any appeal from the denial of that claim.

MEDICAL, DENTAL, AND PRESCRIPTION DRUG CLAIMS

Requirements for Filing a Claim

Medical and Dental Claims

Always present your Plan identification card to any provider of medical care. The ID card indicates to In-Network and Out-of-Area Network providers that you are eligible for higher benefits and other advantages of the networks. The ID card also includes directions to the provider for filing a claim on your behalf. The network providers are required to file the claim on your behalf, and while the Non-Network providers are not required to do so, almost all will file the claims on your behalf.

However, if the Non-Network provider requires you to pay for services, you may file a claim on your own behalf by submitting a copy of the provider's billing statement along with a claim form to the:

Carpenters Health and Welfare Fund Office
1419 Hampton Avenue
St. Louis, Missouri 63139
(314) 644-4802 or
(877) 232-3863 (Toll-Free)

The provider's billing statement must include all of the following information:

- The patient's fill name;

- Your name;
- Diagnosis;
- Dates and description of services rendered; and
- Charges related to each service rendered.

If the patient is covered by more than one group health and welfare plan, see Appendix B for rules about which plan is primary (pays first). The claim should be submitted to the primary plan first. If this plan is secondary, you should submit the explanation of benefits you receive from the primary plan, along with an identical copy of the bill you submitted to the primary plan, to this plan. Send those documents to the Fund Office.

Prescription Drug Claim

To use your prescription drug benefit, you must present your prescription drug ID card when you visit a retail participating pharmacy. You will pay the appropriate co-payment at the time you receive the drugs. To use the mail-order prescription drug benefit, follow the instructions set out in the section titled Mail Order Prescription Drug Program on page 28.

If you believe that the retail or mail order pharmacy has charged you too much or if a pharmacy has refused to provide a drug or refused to accept your card, you may file a claim with the Fund Office. You may do this by sending the Fund Office a copy of the itemized receipt from the pharmacy along with a letter explaining the basis for your claim.

If you use a non-participating pharmacy in an emergency, you must submit a claim for reimbursement to the pharmacy benefit manager at the address shown on your prescription drug ID card. You can obtain claim forms from the Fund Office.

Optional Retiree Medicare Claim

Your Medicare provider will file all claims for you. However, you will be required to make any necessary co-payments at the time of service.

Decision on Post-Service Claims for Medical, Dental, and Prescription Drug Benefits

Upon submission of a claim, the Plan will make a benefit determination within 30 days of receipt. This 30-day time period may be extended for reasons beyond the control of the Plan up to an additional 15 days. Prior to the 30-day initial determination period, you will be notified of the necessity for the extension and the expected resolution date. If such an extension is necessary due to lack of information, you will be notified exactly what information is required to complete the claim and will be given 45 days to provide such information. Please note that the Plan's time limits are tolled while the Plan is waiting for such information to be provided.

In accordance with the regulations set forth by the Department of Labor, if the requested information has not been received after the 45 days have elapsed, the claim will be denied due to lack of information. If the requested information is received after the claim has been denied, all related claims will be reopened and considered in accordance with the appropriate plan of benefits, provided such information is received within one year of the date the charge was incurred.

How Benefits Will Be Paid

Benefits will be considered as soon as the necessary written proof to support the claim is received.

For medical prescription drug and vision charges by Network providers, benefits are paid directly to the physician, hospital, pharmacy or other Network provider. All other benefits are payable to you or directly to the provider of services if you have assigned benefits. However, benefits are not assignable for treatment received from a hospital or ambulatory surgical center located in Massachusetts, and such benefits will be paid directly to you unless the Trustees decide otherwise in their discretion. The Plan will not pay any "hospital surcharge" such as those imposed by the states of Massachusetts and New York.

The Fund Office reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits payable to you and any assignees.

Notification of Adverse Benefit Determination

In the event of an adverse benefit determination, the member will be notified in writing. It will include:

- The specific reason for the adverse benefit determination.
- The specific Plan provision on which the determination was based.
- A description of any additional material or information necessary to perfect the claim and an explanation of why this information is necessary.

- A statement regarding the claimant's right, upon request and free of charge, to access and to receive copies of documents, records and other information relevant to the claim for benefits.
- An explanation of the Plan's appeal procedures, including applicable time limits, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on appeal.
- Information as to whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, and if so, a statement that the claimant may obtain a copy of the rule, guideline, protocol, etc.

If the denial was based in whole or in part on a medical judgment, a statement that an explanation of the medical judgment will be provided free of charge upon written request to the Fund Office.

The member may also have additional rights under the Employee Retirement Income Security Act (ERISA) of 1974. A statement of the ERISA rights can be found at page 65.

Under no circumstances will benefits be paid in connection with a claim filed more than one year after the initial date of service.

HOW TO APPEAL A DENIED CLAIM

Appeal of Adverse Benefit Determination

After receiving notice of claim denial, the covered person or his/her authorized representative must submit a written request to the Board of Trustees for their review and final decision. Any request for review must be filed within 180 days of the date of the claim denial. A request for review must be directed to:

Board of Trustees
℅ Benefit Plans Administrator
Carpenters Health and Welfare Plan
1419 Hampton Avenue
St. Louis, Missouri 63139

When requesting a review, the claimant or his/her authorized representative should state the reason they believe the claim denial was improper and submit any comments, documents, records or other information which is considered appropriate. The Trustees will consider all such submissions as part of the review. The claimant or his/her authorized representative may have reasonable access to, and copies of, all documents, records or other information relevant to the claim upon request free of charge.

As required by law, the Board of Trustees' claim review will not give deference to the original claim decision. If the original claim denial was the result of a medical judgment, the Plan will consult with a healthcare professional who has the appropriate training and experience to render an informed opinion. The healthcare professional will not be the one used for the original claim determination of his/her subordinate. Such individual or entity will be disclosed upon written request to the Board of Trustees.

The Board of Trustees, as fiduciaries of the Plan, will generally make a decision on the review within 45 days after receipt of the request for review, unless special circumstances require an extension of time for processing in which case a decision will be made as soon as possible, but not later than 90 days after receipt of the request for review. If such an extension is required, a claimant or his/her authorized representative will be notified within 45 days after receipt of the request for review.

Notice of the Trustees' decision to deny the appeal in whole or in part on the review will be in writing and will include the specific reasons for the decision, as well as specific references to the pertinent Plan provisions on which the decision is based and other information of the types contained in the initial notice advising the member that the claim has been denied. The decision of the Trustees is final. Any civil action under Section 502(a) of the Employee Retirement Income Security Act must be filed within two years of the date of the Trustees' decision.

Pre-Service Claims for Medical, Dental and Prescription Drug Benefits

All treatment of mental and nervous disorders and substance abuse (except urgent care treatment) requires pre-authorization by the Mental Health Manager Care Company. In addition, there are other services or supplies that require pre-authorization. Such pre-authorization requirements are indicated in the specific descriptions of benefits and in the Managed Care section of this booklet. With respect to these pre-service claims, if the care or treatment which is the subject of the claim has not been provided as of the time the claim is filed or under consideration, an initial decision on the claim shall be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the receipt of the claim by the Plan. If the claim is denied, and if the care or treatment which is subject of the claim has not been provided when an appeal is filed or under consideration, then any such appeal from a denial of the claim shall be decided within 30 days of the Plan's receipt of the appeal. If the care or treatment which is the

subject of the claim has been provided at the time the claim or appeal is filed or under consideration, then the time frames generally applicable to post-service medical claims shall apply.

Concurrent Care Claims

If a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved, the request must be made in writing and the request will be treated as a claim for benefits. The claim will be processed consistently with the rules generally applicable to medical claims, except that if at the time of the submission of the claim, the course of treatment has not been extended, the time for deciding the claim will be a reasonable period of time appropriate to the medical circumstances but not later than 15 days, and the time for deciding any appeal from a denial of such a claim will be 30 days.

If the Plan determines to reduce or terminate a course of treatment it has previously approved, then the Plan will notify he claimant of this decision in writing before the end of such period of time or number of treatments previously approved. The contents of this notice will comply with the rules generally applicable to claim denials and will be provided sufficiently in advance of the reduction or termination of treatment to enable the claimant to appeal and obtain a determination from the Plan before the treatment is terminated or reduced. In the event a claimant receives a notice of the Plan's intention to terminate or reduce previously approved treatment, the claimant will be notified of the date by which he or she must submit an appeal.

Vision Service Claims

Requirements for Filing Claim

Generally, it is not necessary to file a claim for vision benefits if a VSP network doctor is used. Make an appointment with a VSP network doctor and the doctor will confirm your eligibility prior to your appointment. The network doctor will perform the covered services and provide the covered eyewear. The patient will be required to make the appropriate co-payment at the time of service. If the services or eyewear received are not covered or cost in excess of what is covered, the claimant will pay the doctor for the non-covered portion of charges. VSP will reimburse the doctor directly. The claimant does not need to file a claim.

However, if you or a dependent believes a VSP doctor has charged too much or your VSP doctor has refused to provide the services or eyewear, a claim may be submitted by calling:

VSP Member Services
800-877-7195

The Member Services department will help you file a claim in this circumstance.

If a Non-VSP provider is used, the patient gets the services and eyewear and pays the entire bill at the time of service and then files a claim. Be aware that out-of-network benefits do not guarantee full payment. To ensure a timely reimbursement, log on to VSP's web site and access the claim form.

Simply:

- Sign on to vsp.com
- Select the "Out-of-Network Reimbursement Form" under My Forms
- Follow the instructions

If you do not have Internet access, send all of the following to VSP:

- An itemized receipt listing the services received;
- The name, address and phone number of the out-of-network provider;
- The covered member's ID number, name, address and phone number;
- The name of the organization that offers your VSP coverage;
- The patient's name, date of birth, address and phone number; and
- The patient's relationship to the covered member, such as "self," "spouse," "child".

Keep a copy of the claim information and send the originals to:

VSP
P. O. Box 997105
Sacramento, California 95899-7105

Decision on Vision Claim

VSP will evaluate and make a decision with respect to a claim for benefits within 30 days after you submit such a claim. This 30-day limit may be extended by up to 15 days. VSP will, prior to the expiration of the original 30-day period, notify you of the reason for the delay and the date by which a decision can be expected. If the extension of time is necessary due to your failure to submit all information necessary to decide your claim, you will be notified of the additional information needed and your claim will be finalized. When you return the claim to VSP with the additional information, it will be processed as a new claim. As long as the claim, along with the corrections, are submitted within the allowed timeframe for claim submission, VSP will process the claim accordingly.

VSP will review and decide claims and issue notices of any adverse benefit determination using the same procedures and time limits used for post-service medical claims. (See page 54).

Appeal from Denial of Vision Claim

You may appeal from the denial of a claim for vision benefits within 180 days after you are notified of the denial. To appeal, you should write to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, California 95670
(800) 877-7195

You may include any comments, documents, or information you wish. The Plan will provide to you, free of charge, upon your request, copies of all documents, records, and other information relevant to your claim.

ARTICLE XI

GENERAL PLAN PROVISIONS

MISCELLANEOUS PROVISIONS

INFORMATION TO BE FURNISHED

Members and dependents shall provide the Fund 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 Fund 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 Fund 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.

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.

No Guarantee of Tax Consequences

Notwithstanding anything herein to the contrary, the Trustees' neither insure nor make any commitment or guarantee that any amounts paid to 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.

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:

- To his court-appointed guardian or conservator, or
- To his spouse, another member of his family or to any other person, to be expended for his benefit, or
- To an adult person designated by the Trustees as a custodian for him under the Missouri Transfers to Minors Law or similar stature, or
- 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.

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.

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.

Legal Actions

No action at law or in equity shall be brought to recover under the Plan prior to the claimant's exhaustion of the claims and appeals procedures set out in this booklet 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 unless brought within two years from the later of date the Trustees notified the claimant of their decision on the appeal or the date upon which such notification was due from the Trustees.

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.

Rules of Construction

The terms and provisions of this Plan shall be construed according to the principles and in the priority as follows:

- First, in accordance with the meaning under, and which will bring the Plan into conformity with, the Internal Revenue Code and with ERISA; and secondly, in accordance with the laws of the State of Missouri.
- 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 provision of this Plan shall be construed as if such provision had never been included.

Right of Offset and Recovery

If this Plan erroneously pays or overpays benefits or provides for benefits under the subrogation provisions of the Plan to or for any person, the Trustees reserve the right to recover such erroneously paid or defaulted reimbursements, 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 to either the person on whose behalf the erroneous payments were made or any member of that person's family who is also covered under this Plan. The Trustees may also bring a legal action against the member and the person on whose behalf the erroneous payment was made. If the Trustees find it necessary to institute legal proceedings to collect erroneously paid benefits, and they prevail in such proceedings, both the member and person on whose behalf the benefits were paid will be responsible for paying the Trustees reasonable attorney's fees and costs.

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.

Examination of Records

The Plan Administrator will make available to each individual covered by this Plan such records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

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 experts employed or engaged by the Trustees.

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.

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.

Basis of Payments

All Plan assets shall be used exclusively for the following:

- Payment of Plan benefits to covered individuals;
- 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;
- 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.

Board of Trustees

The members of the Board of Trustees of the Carpenters Health and Welfare Trust are named fiduciaries of the Plan and the Administrator of the Plan, as that term is defined in ERISA.

The Trustees have the sole authority to:

- Amend and/or terminate the plan of benefits;
- Make such changes as they deem prudent, from time to time, in the funding policy of the Plan;
- Make such rules as may be necessary for administration of the Plan, construe the plan subject to its provisions, supply any omissions and reconcile any inconsistencies, make equitable adjustments for any mistakes or errors and decide all questions arising in the interpretation of the plan, all of which shall be conclusive and binding on all parties;
- Formulate the claims procedures of the Plan;
- Provide a full, fair, and final review of any claim denied by the Trustees, their employees or by the administrative services provider, if any, retained by the Trustees in accordance with the Plan's claim procedures;
- Comply with the requirements of ERISA with respect to the Plan Document, Summary Plan Description, Annual Report and other reports to be provided to the Secretary of Labor and/or participants;
- Establish, prepare and maintain all records for completion of reports to covered individuals and to governmental agencies;
- Employ, at their option, one or more individuals to perform all or any portion of the day-to-day administration of the Plan;
- Retain, at their option, an actuarial or benefit plan consultant to be responsible for all or any portion of day-to-day administration of the Plan, actuarial valuation, necessary funding and, if desired, assistance in claim determination;
- Purchase, at their option, stop-loss reinsurance with respect to individual or aggregate claims anticipated by the Fund; and
- Be the agent for service of legal process in any legal action for purposes of ERISA.

Any administrative services provider shall perform the duties specified in any separate Administrative Services Agreement entered into between the administrative services provider and the Trustees, the terms and provisions of which shall be incorporated herein by reference to the same extent as if herein written.

The Trustees shall perform their duties and, in their sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Trustees shall interpret all Plan provisions, and make all determinations as to whether any particular covered individual is entitled to receive any benefit under the terms of this Plan, which interpretation shall be made by the Trustees in their sole discretion. Any construction of the terms of the Plan adopted by the Trustees and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Trustees shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Trustees shall be based only on such evidence presented to or considered by the Trustees at the time it made the decision that is the subject of review, and the Trustees' decision shall be entitled to the maximum deference permitted by law.

If any employer and/or any eligible member who performs services for an employer that are or may be compensated for in part by benefits payable pursuant to this Plan, such employer and/or member, by acceptance of such benefits shall be deemed to have agreed and consented to any decisions that the Trustees make, in their sole discretion, and to have further agreed to the limited standard of review described by this document.

ERISA Required Information – Welfare Trust Fund

This Booklet Constitutes the Plan Document and the Summary Plan Description.

This booklet describes your Medical, Prescription Drug, Dental, Vision, Weekly Accident and Sickness, Life Insurance and Safety Enhancement benefits.

The following is additional information required by the Employee Retirement Income Security Act of 1974 (ERISA).

Your booklet is the document governing the Plan. Upon written request, a copy of the Plan will be made available at your work establishment. You may request a copy of the Plan from the Benefit Plan Administrator, Carpenters' Health & Welfare Trust Fund of St. Louis, 1419 Hampton Avenue, St. Louis, Missouri 63139, by paying the cost of the copying.

Plan Name

Carpenters' Health and Welfare Trust Fund of St. Louis

Plan Number

PN501

Employer Identification Number

43-0685432

Plan Sponsor

Trustees of Carpenters' Health and Welfare Trust Fund of St. Louis
1419 Hampton Avenue
St. Louis, Missouri 63139
Telephone: (314) 644-4802

Type of Plan

Welfare plan providing Life, Accidental Death and Dismemberment, Weekly Accident and Sickness, Medical Care, Dental Care, Vision Care and Safety Enhancement Benefits.

Type of Administration

Trustee and Insurer

Plan Administrator

Trustees of Carpenters' Health and Welfare Trust Fund of St. Louis
1419 Hampton Avenue
St. Louis, Missouri 63139
Telephone: (314) 644-4802

Agent for Service of Legal Process

Secretary of the Board of Trustees
Carpenters' Health and Welfare Trust Fund of St. Louis
1419 Hampton Avenue
St. Louis, Missouri 63139

Service of legal process may also be made upon the Plan Administrator and/or the individual Trustees.

Plan Trustees:

Trustees appointed by union

Terry Nelson (Managing Trustee and Secretary)
1401 Hampton Avenue
St. Louis, Missouri 63139

Thomas G. Heinsz
1401 Hampton Avenue
St. Louis, Missouri 63139

Patrick J. Sweeney, III
1401 Hampton Avenue
St. Louis, Missouri 63139

Carmelo D. Caputa
1401 Hampton Avenue
St. Louis, Missouri 63139

Mike Thuston
1401 Hampton
St. Louis, Missouri 63139

Scott Byrne
1401 Hampton
St. Louis, Missouri 63139

Ron Dicus
1401 Hampton
St. Louis, Missouri 63139

Trustees appointed by employers

John P. Mulligan (Chairman)
Mulligan Construction
P.O. Box 436
Ballwin, Missouri 63021

Renee Bell
Waterhout Construction Company
8110 Dale Avenue
St. Louis, Missouri 63117

John W. Fischer
Fischer & Frichtel
7 The Pines Court, Ste. B
St. Louis, Missouri 63141

Ken Stricker
The Jones Company
16440 Chesterfield Grove Road
Chesterfield, Missouri 63005

Kirk Verseman
Missouri Floor Company
2438 Northline Industrial
Maryland Heights, Missouri 63043

Angelo Lancia
Lancia Brothers Woodworking
1436 Kingsland
St. Louis, Missouri 63133

Robert Calhoun
Calhoun Construction Management
6600 W. Main Street (Rear)
Belleville, Illinois 62223

Plan Year Ends:

April 30

Plan Costs

Contributions are made to the Fund by participating employers for active members. The Plan contains a self-payment provision for underemployed, retired, disabled, and self-employed members and surviving spouses.

Plan Benefit and Disbursements

Most of the benefits provided by the Plan are paid directly out of the assets of the Plan. However, the life insurance and accidental death and dismemberment benefits and the optional Medicare HMO benefits for retirees are provided through policies of insurance. Further, even with respect to the benefits that are paid out of the assets of the Plan, the Trustees have made arrangements with a number of companies to help in the administration of the benefits and, in some cases, to make disbursements.

The following entities play the following roles in providing and administering your benefits.

Medical Benefits

Carpenters Health and Welfare Fund Office
1419 Hampton Avenue
St. Louis, Missouri 63139
Telephone: (314) 644-4802

The Fund Office reviews, decides and makes disbursements for all medical, dental, weekly accident and sickness benefits. However, the Plan uses the following companies to provide services in connection with those benefits.

In-Network and Medical Care Management Company

CMR
111 Corporate Drive
Earth City, Missouri 63045
(800) 775-3540

The Plan pays CMR a fee to provide individuals covered by this Plan with access to its local Network of doctors, hospitals and other providers which have agreed to accept negotiated, often discounted, fees for services they render to those covered individuals. CMR also provides Managed Care services required with reference to medical treatments. CMR does not insure or guarantee your benefits.

Out-of-Area Network

First Health
1507 N. Falkenburg Road
Tampa, FL 33619
(866) 676-7424

The Plan pays First Health a fee to provide individuals covered by this Plan access to the Out-of-Area Network of doctors, hospitals and other providers which have agreed to accept negotiated, often discounted, fees for services they render to those covered individuals. First Health does not insure or guarantee your benefits.

Mental Health Network and Managed Mental Health Care Company

Unity Health Network
1000 Des Peres Road
St. Louis, MO 63131
(314) 729-4600
(800) 413-8008

The Plan pays Unity Health Network a fee to provide individuals covered by this Plan access to the Unity Network of providers of treatment for mental and nervous disorders and substance abuse who have agreed to accept negotiated, often discounted, fees for services they render to those covered individuals. Unity also performs the pre-authorization services that are required for all treatment of mental and nervous disorders and substance abuse. Finally, Unity provides the member assistance program. Unity does not insure or guarantee your benefits.

Medical Care Managers

Primary Pediatric Management
1419 Bridle Road
Webster Groves, MO 63119
(314) 963-1307

Welker and Associates
13531 Hwy D
Louisiana, MO 63353
(866) 754-4900

Choice Care Management, LLC
4679 Shoshone Trail
St. Charles, MO 63304
(636) 928-9494

These three companies provide medical care management services for covered individuals with health conditions.

Building Blocks Prenatal Program

Trilogy Healthcare, Inc.
1837 Craigshire
St. Louis, MO 63304
(877) 275-7799

Retail Pharmacy Benefit Manager (PBM)

PharmaCare, Inc.
PO Box 2860
Pittsburgh, PA 15230-2860
(888) 645-9303

The Plan pays a fee to this company so that covered individuals have access to this company's network of retail pharmacies. PharmaCare has arrangements with the pharmacies in its network pursuant to which those pharmacies agree to accept pre-negotiated, often discounted, amounts for drugs they provided to covered individuals. This company also receives and adjudicates claims for retail pharmacy benefits on

behalf of the Plan. If you purchase a prescription at a Non-Network retail pharmacy, you must submit a claim for reimbursement to PharmaCare. PharmaCare does not insure or guarantee your benefits.

Mail Order Prescription Drug Company

Med Script Services
10447 Breckenridge Road
St. Ann, Missouri 63074
(314) 427-0756
Contract #: Carpenters Health

Med Script receives, processes and fills your mail-order prescriptions. The Plan pays Med Script for its services and for the covered cost of the prescription. Med Script does not insure or guarantee your benefits.

Vision Care Benefits

VSP
3333 Quality Drive
Rancho Cordova, California 95670
(800) 852-7600
Contract #: 12103612 and 12143784

VSP is a named fiduciary of the Plan.

The Plan pays a fee to VSP for its administrative services so that its covered individuals have access to VSP's network of providers who have agreed to accept pre-negotiated, often discounted, amounts in payment for services and eyewear supplied to those covered individuals. VSP also processes claims for services and eyewear supplied by non-VSP providers. VSP does not insure or guarantee the vision benefits.

Optional Retiree Medicare Benefits

United HealthCare of the Midwest
Medicare Complete
13655 Riverport Drive
Maryland Heights, Missouri 63043
(314) 592-7000
Policy #: 55014

Group Health Plan
Gold Advantage
111 Corporate Office Drive, Suite 400
Earth City, Missouri 63045
(800) 533-0367

These Medicare HMOs make all decisions, pays claims for, and insures the benefits provided by the HMO.

Life, Dependent Life and Accident Death & Dismemberment Benefits

MetLife
ATTENTION: Life Claims Department
P. O. Box 6115
Utica, New York 13504-6115
(800) 638-6420 (Phone)
(315) 792-5824 (Fax)
Policy #: 102703-G

MetLife is a named fiduciary of the Plan.

MetLife makes all decisions, pays claims for, and insures the life and accidental death and dismemberment benefits.

Summary

A complete copy of any of these policies may be obtained by contacting the Fund Office.

The contracts the provider networks have with providers and administrators may provide for additional discounts, allowances, fees, incentives, adjustments or settlements to be paid to or retained by such provider networks. The provider networks may retain any such payments or they may distribute or share these amounts with providers, administrators or the Trust. However, all co-payments, deductibles and/or coinsurance remain your responsibility, calculated without regard to such payments. Some providers and administrators may also participate in incentive and other programs, under which such providers and administrators may be entitled to additional payments for effectively managing care and/or for member/provider satisfaction.

In addition, the Trust's contract with PharmaCare and/or Med Script may provide for the sharing in manufacturers' rebates. However, the co-payments, deductibles, and/or coinsurance that are your responsibility will be calculated without regard to such rebates.

Collective Bargaining Agreement

The Plan is maintained pursuant to collective bargaining agreements between the participating employers and the Carpenters' District Council of Greater St. Louis. You may obtain a copy of the applicable bargaining agreement by contacting the Fund Office.

Plan Eligibility and Benefits

- Details of the Plan are described in this booklet.
- Circumstances that may result in disqualification, ineligibility or denial, loss or suspension of benefits are described in the booklet.

Termination or Amendment of the Plan

The plan may be amended or terminated by the Trustees in accordance with the terms of the Trust Agreement and the applicable collective bargaining agreements. In the event the plan is terminated, any remaining funds will be used for benefits until the funds are exhausted (see page 59).

Participating Employers

A participant or beneficiary may receive from the Plan Administrator upon written request, a statement as to whether a particular employer is a participating employer and the address of that participating employer.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as union halls and work sites, all documents governing the plan, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with U.S. Department of Labor, such as detailed annual reports (Form 5500 Series).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition, if you are a participant in a group health plan, you have the right to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for information concerning your COBRA continuation coverage rights.
- Reduce or eliminate of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- Receive a copy of the plan’s Qualified Medical Child Support procedures without charge from the Plan Administrator.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day

until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Protection of Privacy of Health Information

The term "protected health information" ("PHI"), and all other terms defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or in regulations promulgated thereunder in 45 Code of Federal Regulations Parts 160 through 164, shall have the same defined meanings when used in the Plan provisions under this heading.

The Board of Trustees (the "Board") shall implement and maintain administrative, physical and technical safeguards that a reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

The Board shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.

The Board shall report to the Plan administrator any security incident of which it becomes aware.

If the Board shall receive or acquire PHI, the Board shall use or disclose such PHI only to the extent necessary to perform its functions in accordance with the Plan Document, the Trust Agreement, and applicable law; provided, that no such use or disclosure of PHI by the Board shall be inconsistent with subpart E of 45 CFR Part 164.

The Plan and its agents shall not disclose PHI to the Board unless the Board has certified that the Plan Document has been amended to provide that the Board shall, and the Board agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents, including a subcontractor, to whom it provides PHI, agree to the same restrictions and conditions that apply to the Board with respect to such information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI in accordance with 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with subpart E of 45 CFR Part 164;
- If feasible, return or destroy all PHI received from the Plan that the Board still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the separation described in the following paragraph is established:
    - Access to PHI disclosed to the Board shall be given by the Board to the following employees, classes of employees and other persons under the control of the Board, but in each case only to the extent necessary for such employees and other persons to perform their respective duties and responsibilities within the Plan administration functions that the Board performs for the Plan: The Benefit Plans Administrator; the Assistant Administrator; claims processors and their supervisors; any other employee or person who receives PHI relating to payment under, health care operations

of, or other matters pertaining to the Plan in the ordinary course of business; and the Plan's professional consultants and advisors. In the event that any noncompliance by any such employee or other person with the foregoing provisions is reported to or otherwise comes to the attention of the Board, the Board shall investigate the same and shall take such measures as necessary to prevent its recurrence, including where appropriate reeducation, reprimand or other disciplinary action.

The Board shall ensure that this adequate separation is supported by reasonable and appropriate security measures.

This booklet supersedes and replaces Health and Welfare Booklets, if any, previously issued to you.

This revised and restated Plan Document is adopted this **23rd** day of **February**, **2006**,
at St. Louis, Missouri.

CARPENTERS' HEALTH AND WELFARE TRUST FUND OF ST. LOUIS

APPENDIX A

MAINTENANCE OF COVERAGE UNDER UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT

CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A covered member, who is on a leave protected by the Uniformed Services Employment and Reemployment Act of 1994 ("Military Leave"), may choose to maintain his coverage, and the coverage of his eligible dependents who were covered by the plan on the day immediately prior to such leave, for the duration of his Military Leave at the level and under the conditions such coverage would have been provided if he had continued active work. The covered member's right to maintain such coverage shall end on the earliest of the following to occur:

- The date the covered member terminates employment by either notifying his employer that he does not intend to return from Military Leave or by failing to return from Military Leave within the time specified by law for protecting rights under the Act.
- The last day of the 18-month period beginning on the first day of Military Leave.
- Any other date permitted by law.

Continuation of coverage under this provision shall run concurrently with COBRA continuation of coverage and shall be credited towards satisfaction of the maximum coverage periods specified in that provision, to the extent permitted by law.

Premium Amount

A covered member on Military Leave that does not exceed 30 days shall pay a premium at the same rate (if any) that the member would have paid to maintain active coverage at work during the leave period. A covered member on Military Leave that exceeds 30 days shall pay a premium at the rate provided for in the Self-payment provisions – Active Classification section or the COBRA Continuation of Coverage section of this Summary Plan Description/Plan Document.

APPENDIX B

MULTIPLE COVERAGE LIMITATIONS

COORDINATION OF BENEFITS

GENERALLY

All benefits of this plan shall be subject to these Coordination of Benefits provisions. Any questions not addressed by the express language of the Plan will be determined in accordance with the guidelines outlined by the National Association of Insurance Commissioner (NAIC).

Definitions

As used in this Appendix, the following terms, whether or not capitalized, shall have the meanings indicated:

1. **"Plan"** means any plan providing benefits for or by reason of medical, dental, vision, or prescription drug care or treatment which benefits or services are paid for, payable or furnished by any of the types of coverage, plans or programs listed below or any other group or blanket-type contracts or plans as are not available to the general public and under which benefits for an individual and his dependents can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group, except as otherwise provided in this item 1:

    a. Any group or blanket insurance plan or any other plan covering individuals or members as a group.

    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. Where permitted by federal law, any coverage under government programs or any coverage required or provided by any statute, other than Medicaid.

    e. Any coverage for students that is sponsored by, or provided through a school or other educational institution.

    In addition, the term "Plan" shall include medical benefits coverage under group or individual automobile insurance policies, group or individual no-fault automobile insurance coverage, and individual or family subscriber policies or contracts issued under a group or blanket-type plan, but shall not include hospital indemnity-type contracts.

    The term "Plan" shall be construed separately with respect to each program, policy, contract or other arrangement for benefits or services, or portion thereof, which constitutes a "Plan." "Plan" shall also be construed separately with respect to that portion of each program, policy, contract or other arrangement which reserves the right to take benefits for services of other plans into consideration in determining its benefits and that portion which does not.

2. **"Allowable Expense"** means a health care service or expense, including deductibles, coinsurance or co-payments, that is covered in full or in part by any of the plans covering the person up to patient responsibility, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

    a. When the amount of the expense is determined differently by both plans using reasonable and customary (R & C) standards, the higher determination of what is reasonable and customary is the allowable expense.

    b. When the amount of the expense is determined differently by both plans using negotiated fees, any amount in excess of the higher negotiated fee is usually not an allowable expense, and the amount that the secondary plan pays to the provider is generally determined by the contract between that plan and the provider.

    c. If one plan uses the R&C standard while the other uses a negotiated fee to determine how much it must pay, the amount determined by the primary plan's method must be used to determine the secondary plan's liability.

d. The difference between the cost of a private hospital room and a semi-private room is not an allowable expense, unless confinement in a private room is medically necessary.

e. Any reduction of benefits by the primary plan for failing to comply with its utilization review requirements (such as requirements for preauthorization), or for using an out-of-network provider, is not an allowable expense that must be considered by the secondary plan in determining its secondary liability.

f. When a closed panel (or HMO) plan provides services rather than the reimbursement of expenses, the reasonable cash value of those services is both an allowable expense and the benefit paid by that plan. However, when a participant in a primary closed panel (or HMO) plan obtains non-emergency, out-of-network services for which the closed panel (or HMO) plan has no liability, a secondary indemnity plan must pay its benefits as if it were primary.

g. A charge for any service expressly excluded from coverage by this Plan is not an allowable expense for the Plan.

3. **"Benefit Determination Period"** means a period from January 1 of each year through December 31 of the same year, inclusive.

Benefit Determination

The benefits payable under this plan shall be subject to the following:

1. This multiple coverage provision shall apply in determining the benefits as to a person covered under this plan for any Benefit Determination Period if the sum of:

   a. the benefits that would otherwise be payable under this plan in the absence of this provision; and

   b. the benefits that would otherwise be payable under all other plans in the absence therein of provisions of similar purpose to this provision;

   exceed the Allowable Expenses incurred by or on behalf of such person during such period.

2. As to any Benefit Determination Period with respect to which this provision is applicable, the benefits that would otherwise be payable under this plan in the absence of this provision for the Allowable Expenses incurred by or on behalf of such person during such Benefit Determination Period shall be reduced, except as provided in item 3. below, to the extent necessary so that the sum of such reduced benefits and all the benefits paid for, payable or furnished in connection with such Allowable Expenses under all other plans shall not exceed the total of such Allowable Expenses. For the purposes of this provision, all benefits payable or furnished under another plan shall be taken into account whether or not a claim has been duly made therefore.

   In addition, with respect to individuals for whom the plan is permitted by law to take Medicare benefits into consideration (see page 46), benefits payable under another plan shall be deemed to include the following:

   a. The amount of benefits that would have been payable by Medicare Parts A and B if the covered individual had enrolled for such coverage and a claim had been duly made therefore. In the event that the covered individual has either (1) not enrolled for such Medicare coverage, or (2) has not made a claim for Medicare benefits, the covered individual shall be deemed to have received Medicare benefits in an amount determined in accordance with the deductible and coinsurance factors then applicable under original Medicare, and in accordance with the covered expense definition of this plan. The preceding sentence will not apply to benefits under Hospital Insurance (Part A) of Medicare with respect to an individual whose eligibility for such Hospital Insurance (Part A) of Medicare requires payment of premium.

   b. Any benefits paid or payable by another group plan due to its obligation to provide benefits without regard to Medicare coverage for an actively working employee or dependent of such person.

3. If coverage under another plan is involved, as provided in item 2. above, and:

   a. such plan contains a provision coordinating the benefits thereunder with those of this plan and according to its terms and conditions, benefits thereunder would not be determined until after the benefits of this plan have been determined; and

   b. the terms and conditions set forth in item 4. below would require benefits under this plan to be determined before benefits are determined under such other plan;

   then the benefits otherwise provided under such other plan will not be taken into account for the purposes of determining the benefits under this plan.

4. For the purposes of item 3. above, the basis for establishing the order of benefit determination shall be as follows:

    a. The benefits of a plan that covers the person on whom claim is based other than as a dependent shall be determined before the benefits of a plan that covers such person as a dependent, referred to as the Nondependent or Dependent rule.

    b. The benefits of a plan which covers a child as the dependent of the parent whose birthday occurs first during the calendar year shall be determined before the benefits of a plan which covers such person as a dependent of the parent whose birthday occurs later in the year, referred to as the Birthday rule.

    c. In the case of a person for whom claim is made as a dependent child of separated, divorced, or unmarried parents, when the parents are legally separated, divorced, or unmarried and the parent with physical custody of the child has not remarried, the benefits of a plan that covers the child as a dependent of the parent with physical custody of the child will be determined before the benefits of a plan that covers the child as a dependent of the parent without such custody;

        i. If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plan of the parents and the parent's' spouses (if any) is:

            (1) The plan of the custodial parent;

            (2) The plan of the spouse of the custodial parent;

            (3) The plan of the non-custodial parent; and then

            (4) The plan of the spouse of the non-custodial parent

        Notwithstanding (1) and (2) above, **if there is a court decree that would otherwise establish financial responsibility, the benefits of the plan that covers the child as a dependent of the parent with such court-assigned financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent.** If the terms of the court decree state that the parents shall share joint physical custody without stating that one of the parents is responsible for the health care expenses of the child, this plan shall follow the rule set forth in item 4.b. above.

    d. When rules a., b. and c. do not establish an order of benefit determination, the benefits of a plan which has covered the person on whom claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time; provided, however, that:

        i. The benefits of a plan covering a person as a retired or disabled former employee shall be determined after the benefits of any other plan covering such person as an employee who is not a retired or disabled former employee. Except as provided in subparagraph (iv) below, a plan covering a person on account of extended eligibility earned while an active employee shall be considered to cover such person as an employee who is not retired or disabled, regardless whether such person would otherwise be considered an employee during the period of extended eligibility.

        ii. The benefits of a plan covering a person as a dependent of a retired or disabled former employee shall be determined after the benefits of any other plan covering such person as a dependent of an employee who is not a retired or disabled former employee.

        iii. If either plan does not have a provision regarding retired employees and, as a result, each plan determines its benefits after the other, the provisions of subparagraph (i) above shall not apply.

        iv. The benefits of a plan covering the person on whose expense the claim is based under federal or state continuation laws shall be determined after the benefits of any other plan covering such person as an employee, member or subscriber or a dependent of such person.

        v. If either plan does not have a provision regarding federal or state continuation coverage, and as a result, each plan determines its benefits after the other, the provisions of subparagraph (iv) above shall not apply.

5. If one or more of the other plans involved (as defined in this Multiple Coverage Provision) provides benefits on an excess insurance or excess coverage basis, items 3 and 4 of the benefit determination provisions shall not apply to such plan(s) and this plan will pay as excess coverage.

When this coordination of benefit provision operates to reduce the total amount of benefits otherwise payable with respect to a person covered under this plan during any Benefit Determination Period, each benefit that would otherwise be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against the lifetime maximum benefit of this plan.

6. Primary coverage under Medicare Parts A and B.

SUBROGATION AND REIMBURSEMENT

GENERALLY

If a person covered by this Plan (a "covered person") sustains an injury or sickness for which a third party is legally liable to make payment or does make payment, the Plan is not obligated to pay any benefits on account of such injury or sickness. Any such payment made by a third party on account of an injury or sickness for which the Plan paid benefits is referred to herein as a "third-party recovery."

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 until the liability of the third party is finally determined. In such a situation, the Trustees may instead, in their discretion, advance benefits to the covered person who sustained the injury or sickness, subject to the terms and conditions of this Appendix.

For purposes of this Appendix, a covered person's own automobile insurance carrier is deemed a third party with respect to uninsured or underinsured coverages.

SUBROGATION

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

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

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

THE COVERED PERSON'S REIMBURSEMENT OBLIGATION

In the event that a covered person shall recover any amount from a third party, by judgment, settlement or otherwise, for an act or omission causing 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 whether any part of the recovery is allocated, by judgment or agreement, to components of damage other than medical expense.

b. The Plan 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, and 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 interest 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 insuror, or anyone else of the Plan's lien and other rights with respect to a third-party recovery.

d. The covered person, and anyone acting on his or her behalf, shall hold the third-party recovery In Trust, as trustee, for the benefit of the Plan, to be applied first in satisfaction of the reimbursement obligation of the covered person.

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 his or her eligible dependents.

f. A member is responsible for performing all obligations of the member's eligible spouse and other eligible dependents under this Appendix.

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 to 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 claim to be filed against a covered person's uninsured or underinsured portion of their own automobile policy in order to satisfy the balance of the covered person's reimbursement obligation.

The Covered Person's Duty to Cooperate with the Plan

If the Trustees decide to advance benefits for an injury or sickness for which a third party may be liable, the Plan may require at any time, as a condition of payment of benefits, that the covered person sign a written agreement which may 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's signature to signify that the attorney will comply with such agreement. The Plan's rights under this Appendix are not dependent upon any such agreement.

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.

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 and expenses unless by express written agreement of the Plan.

A covered person shall cooperate with the Plan and do whatever is necessary to secure the rights of the Plan under this Appendix. The covered person shall do nothing to prejudice the Plan's rights of subrogation and reimbursement.

APPENDIX C

DENTAL FEE SCHEDULE

ADA	Description of Service	Fee
PREVENTIVE		
D0120	Periodic oral evaluation	$25
D0140	Limit oral eval problm focus	$32
D0150	Comprehensve oral evaluation	$25
D0160	Extensv oral eval prob focus	$62
D0170	Re-eval,est pt,problem focus	$32
D0180	Comp periodontal evaluation	$62
D0210	Intraor complete film series	$70
D0220	Intraoral periapical first f	$12
D0230	Intraoral periapical ea add	$10
D0240	Intraoral occlusal film	$18
D0250	Extraoral first film	$30
D0260	Extraoral ea additional film	$20
D0270	Dental bitewing single film	$15
D0272	Dental bitewings two films	$20
D0274	Dental bitewings four films	$36
D0277	Vert bitewings-sev to eight	$36
D0290	Dental film skull/facial bon	$35
D0310	Dental saliography	$40
D0320	Dental tmj arthrogram incl I	$193
D0321	Dental other tmj films	$28
D0322	Dental tomographic survey	$140
D0330	Dental panoramic film	$50
D0340	Dental cephalometric film	$68
D0350	Oral/facial images	$21
D0415	Bacteriologic study	$61**
D0425	Caries susceptibility test	$10
D0460	Pulp vitality test	$15
D0470	Diagnostic casts	$35
D0472	Gross exam, prep & report	$53
D0473	Micro exam, prep & report	$63
D0474	Micro w exam of surg margins	$73
D0480	Cytopath smear prep & report	$108
D0502	Other oral pathology procedu	BR
D0999	Unspecified diagnostic proce	BR
D1110	Dental prophylaxis adult	$51
D1120	Dental prophylaxis child	$31
D1201	Topical fluor w prophy child	$45
D1203	Topical fluor w/o prophy chi	$12
D1204	Topical fluor w/o prophy adu	Not Covered
D1205	Topical fluoride w/ prophy a	$51
D1310	Nutri counsel-control caries	$24
D1320	Tobacco counseling	Not Covered
D1330	Oral hygiene instruction	Not Covered
D1351	Dental sealant per tooth	$24
RESTORATIVE		
D1510	Space maintainer fxd unilat	$126
D1515	Fixed bilat space maintainer	$140
D1520	Remove unilat space maintain	$141
D1525	Remove bilat space maintain	$170
D1550	Recement space maintainer	$25
D2140	Amalgam one surface permanen	$30
D2150	Amalgam two surfaces permane	$45
D2160	Amalgam three surfaces perma	$65
D2161	Amalgam 4 or > surfaces perm	$72
D2330	Resin one surface-anterior	$36
D2331	Resin two surfaces-anterior	$51
D2332	Resin three surfaces-anterio	$80
D2335	Resin 4/> surf or w incis an	$82
D2390	Ant resin-based cmpst crown	$46
D2391	Post 1 srfc resinbased cmpst	$36
D2392	Post 2 srfc resinbased cmpst	$45
D2393	Post 3 srfc resinbased cmpst	$60
D2394	Post >=4srfc resinbase cmpst	$89
D2410	Dental gold foil one surface	$45
D2420	Dental gold foil two surface	$60
D2430	Dental gold foil three surfa	$60
D2510	Dental inlay metalic 1 surf	$95
D2520	Dental inlay metallic 2 surf	$173
D2530	Dental inlay metl 3/more sur	$212
D2542	Dental onlay metallic 2 surf	$263
D2543	Dental onlay metallic 3 surf	$375
D2544	Dental onlay metl 4/more sur	$385
D2610	Inlay porcelain/ceramic 1 su	$212
D2620	Inlay porcelain/ceramic 2 su	$206
D2630	Dental onlay porc 3/more sur	$212
D2642	Dental onlay porcelin 2 surf	$335
D2643	Dental onlay porcelin 3 surf	$380
D2644	Dental onlay porc 4/more sur	$444
D2650	Inlay composite/resin one su	$190
D2651	Inlay composite/resin two su	$285
D2652	Dental inlay resin 3/mre sur	$373
D2662	Dental onlay resin 2 surface	$310
D2663	Dental onlay resin 3 surface	$380
D2664	Dental onlay resin 4/mre sur	$406
D2710	Crown resin laboratory	$125
D2720	Crown resin w/ high noble me	$264
D2721	Crown resin w/ base metal	$235
D2722	Crown resin w/ noble metal	$235
D2740	Crown porcelain/ceramic subs	$272
D2750	Crown porcelain w/ h noble m	$302
D2751	Crown porcelain fused base m	$264
D2752	Crown porcelain w/ noble met	$264
D2780	Crown 3/4 cast hi noble met	$275
D2781	Crown 3/4 cast base metal	$199
D2782	Crown 3/4 cast noble metal	$229
D2783	Crown 3/4 porcelain/ceramic	$290
D2790	Crown full cast high noble m	$240
D2791	Crown full cast base metal	$198
D2792	Crown full cast noble metal	$198
D2799	Provisional crown	$153
D2910	Dental recement inlay	$26
D2920	Dental recement crown	$28
D2930	Prefab stnlss steel crwn pri	$86
D2931	Prefab stnlss steel crown pe	$86
D2932	Prefabricated resin crown	$70
D2933	Prefab stainless steel crown	$100
D2940	Dental sedative filling	$25
D2950	Core build-up incl any pins	$70
D2951	Tooth pin retention	$12
D2952	Post and core cast + crown	$87
D2953	Each addtnl cast post	$98
D2954	Prefab post/core + crown	$87
D2955	Post removal	$360
D2957	Each addtnl prefab post	$56
D2960	Laminate labial veneer	$110**
D2961	Lab labial veneer resin	$161**
D2962	Lab labial veneer porcelain	$265 **
D2970	Temporary- fractured tooth	$61
D2980	Crown repair	$76**
D2999	Dental unspec restorative pr	BR
D3110	Pulp cap direct	$22
D3120	Pulp cap indirect	$22
D3220	Therapeutic pulpotomy	$47
D3221	Gross pulpal debridement	$64
D3230	Pulpal therapy anterior prim	$116
D3240	Pulpal therapy posterior pri	$116
D3310	Anterior	$249
D3320	Root canal therapy 2 canals	$306
D3330	Root canal therapy 3 canals	$390
D3331	Non-surg tx root canal obs	$90
D3332	Incomplete endodontic tx	$97
D3333	Internal root repair	$47
D3346	Retreat root canal anterior	$241**
D3347	Retreat root canal bicuspid	$281**
D3348	Retreat root canal molar	$346**
D3351	Apexification/recalc initial	$84
D3352	Apexification/recalc interim	$94
D3353	Apexification/recalc final	$189
D3410	Apicoect/perirad surg anter	$174
D3421	Root surgery bicuspid	$177
D3425	Root surgery molar	$189
D3426	Root surgery ea add root	$70

D3430	Retrograde filling	$81
D3450	Root amputation	$151
D3460	Endodontic endosseous implant	$279**
D3470	Intentional replantation	$180**
D3910	Isolation- tooth w rubb dam	Not Covered
D3920	Tooth splitting	$54
D3950	Canal prep/fitting of dowel	Not Covered
D3999	Endodontic procedure	BR
D4210	Gingivectomy/plasty per quad	$180
D4211	Gingivectomy/plasty per toot	$54
D4240	Gingival flap proc w/ planin	$172
D4241	Gngvl flap w rootplan 1-3 th	$86
D4245	Apically positioned flap	$231
D4249	Crown lengthen hard tissue	$329
D4260	Osseous surgery per quadrant	$342
D4261	Osseous surgery one to three	$114
D4261	Osseous surgery one to three	$114
D4263	Bone replce graft first site	$114**
D4263	Bone replce graft first site	$329
D4264	Bone replce graft each add	$88**
D4265	Bio mtrls to aid soft/os reg	BR
D4266	Guided tiss regen resorble	$125**
D4267	Guided tiss regen nonresorb	$287**
D4268	Guided tissue regeneration	$238
D4270	Pedicle soft tissue graft pr	$86
D4271	Free soft tissue graft proc	$171
D4273	Subepithelial tissue graft	$210**
D4274	Distal/proximal wedge proc	$145**
D4275	Soft tissue allograft	$193**
D4276	Con tissue w dble ped graft	BR
D4320	Provision splnt intracoronal	$26
D4321	Provisional splint extracoro	$26
D4341	Periodontal scaling & root	$52
D4342	Periodontal scaling 1-3teeth	$39
D4355	Full mouth debridement	$84
D4381	Localized chemo delivery	$7
D4910	Periodontal maint procedures	$41
D4920	Unscheduled dressing change	$46
D4999	Unspecified periodontal proc	BR

MAJOR RESTORATIVE

D5110	Dentures complete maxillary	$311
D5120	Dentures complete mandible	$311
D5130	Dentures immediat maxillary	$311
D5140	Dentures immediat mandible	$311
D5211	Dentures maxill part resin	$217
D5212	Dentures mand part resin	$217
D5213	Dentures maxill part metal	$353
D5214	Dentures mandibl part metal	$353
D5281	Removable partial denture	$154
D5410	Dentures adjust cmplt maxil	$13
D5411	Dentures adjust cmplt mand	$13
D5421	Dentures adjust part maxill	$13
D5422	Dentures adjust part mandbl	$13
D5510	Dentur repr broken compl bas	$46
D5520	Replace denture teeth complt	$19
D5610	Dentures repair resin base	$46
D5620	Rep part denture cast frame	$64
D5630	Rep partial denture clasp	$19
D5640	Replace part denture teeth	$19
D5650	Add tooth to partial denture	$56
D5660	Add clasp to partial denture	$81
D5710	Dentures rebase cmplt maxil	$175
D5711	Dentures rebase cmplt mand	$175
D5720	Dentures rebase part maxill	$140
D5721	Dentures rebase part mandbl	$140
D5730	Denture reln cmplt maxil ch	$43
D5731	Denture reln cmplt mand chr	$86
D5740	Denture reln part maxil chr	$43
D5741	Denture reln part mand chr	$72
D5750	Denture reln cmplt max lab	$82
D5751	Denture reln cmplt mand lab	$82
D5760	Denture reln part maxil lab	$82
D5761	Denture reln part mand lab	$126
D5810	Denture interm cmplt maxill	Not Covered
D5811	Denture interm cmplt mandbl	Not Covered
D5820	Denture interm part maxill	$159**
D5821	Denture interm part mandbl	$162**
D5850	Denture tiss conditn maxill	$27
D5851	Denture tiss condtin mandbl	$34
D5860	Overdenture complete	BR
D5861	Overdenture partial	BR
D5862	Precision attachment	BR
D5867	Replacement of precision att	$39**
D5875	Prosthesis modification	$77**
D5899	Removable prosthodontic proc	BR
D5911	Facial moulage sectional	$68
D5912	Facial moulage complete	$102
D5982	Surgical stent	$203
D5983	Radiation applicator	BR
D5984	Radiation shield	BR
D5985	Radiation cone locator	$474
D5986	Fluoride applicator	$50**
D5987	Commissure splint	BR
D5988	Surgical splint	$177**
D5999	Maxillofacial prosthesis	BR
D6010	Odontics endosteal implant	BR
D6020	Odontics abutment placement	BR
D6040	Odontics eposteal implant	BR
D6050	Odontics transosteal implnt	BR
D6053	Implnt/abtmnt spprt remv dnt	BR
D6054	Implnt/abtmnt spprt remvprtl	BR
D6055	Implant connecting bar	BR
D6056	Prefabricated abutment	BR
D6057	Custom abutment	BR
D6058	Abutment supported crown	$238**
D6059	Abutment supported mtl crown	BR
D6060	Abutment supported mtl crown	BR
D6061	Abutment supported mtl crown	BR
D6062	Abutment supported mtl crown	BR
D6063	Abutment supported mtl crown	BR
D6064	Abutment supported mtl crown	BR
D6065	Implant supported crown	BR
D6066	Implant supported mtl crown	BR
D6067	Implant supported mtl crown	BR
D6068	Abutment supported retainer	BR
D6069	Abutment supported retainer	BR
D6070	Abutment supported retainer	BR
D6071	Abutment supported retainer	BR
D6072	Abutment supported retainer	BR
D6073	Abutment supported retainer	BR
D6074	Abutment supported retainer	BR
D6075	Implant supported retainer	BR
D6076	Implant supported retainer	BR
D6077	Implant supported retainer	BR
D6078	Implnt/abut suprtd fixd dent	BR
D6079	Implnt/abut suprtd fixd dent	BR
D6080	Implant maintenance	BR
D6090	Repair implant	BR
D6095	Odontics repr abutment	BR
D6100	Removal of implant	BR
D6199	Implant procedure	BR
D6210	Prosthodont high noble metal	$186
D6211	Bridge base metal cast	$151
D6212	Bridge noble metal cast	$151
D6240	Bridge porcelain high noble	$239
D6241	Bridge porcelain base metal	$214
D6242	Bridge porcelain nobel metal	$214
D6245	Bridge porcelain/ceramic	$153
D6250	Bridge resin w/high noble	$204
D6251	Bridge resin base metal	$153
D6252	Bridge resin w/noble metal	$153
D6545	Dental retainr cast metl	$118**
D6548	Porcelain/ceramic retainer	$226**
D6600	Porcelain/ceramic inlay 2srf	BR
D6601	Porc/ceram inlay >= 3 surfac	BR
D6602	Cst hgh nble mtl inlay 2 srf	BR
D6603	Cst hgh nble mtl inlay >=3sr	BR
D6604	Cst bse mtl inlay 2 surfaces	BR
D6605	Cst bse mtl inlay >= 3 surfa	BR
D6606	Cast noble metal inlay 2 sur	BR
D6607	Cst noble mtl inlay >=3 surf	BR
D6608	Onlay porc/crmc 2 surfaces	BR
D6609	Onlay porc/crmc >=3 surfaces	BR
D6610	Onlay cst hgh nbl mtl 2 srfc	BR
D6611	Onlay cst hgh nbl mtl >=3srf	BR
D6612	Onlay cst base mtl 2 surface	BR
D6613	Onlay cst base mtl >=3 surfa	BR
D6614	Onlay cst nbl mtl 2 surfaces	BR
D6615	Onlay cst nbl mtl >=3 surfac	BR
D6720	Retain crown resin w hi nble	$220

D6721	Crown resin w/base metal	$196
D6722	Crown resin w/noble metal	$196
D6740	Crown porcelain/ceramic	$200
D6750	Crown porcelain high noble	$252
D6751	Crown porcelain base metal	$220
D6752	Crown porcelain noble metal	$220
D6780	Crown 3/4 high noble metal	$168
D6781	Crown 3/4 cast based metal	$159
D6782	Crown 3/4 cast noble metal	$160
D6783	Crown 3/4 porcelain/ceramic	$161
D6790	Crown full high noble metal	$200
D6791	Crown full base metal cast	$165
D6792	Crown full noble metal cast	$165
D6793	Provisional retainer crown	$80
D6920	Dental connector bar	$339
D6930	Dental recement bridge	$30
D6940	Stress breaker	$51
D6950	Precision attachment	$115
D6970	Post & core plus retainer	$72
D6971	Cast post bridge retainer	$136
D6972	Prefab post & core plus reta	$102
D6973	Core build up for retainer	$136
D6975	Coping metal	$21**
D6976	Each addtnl cast post	$84
D6977	Each addtl prefab post	$45
D6980	Bridge repair	$94**
D6985	Pediatric partial denture fx	BR
D6999	Fixed prosthodontic proc	BR
D7111	Coronal remnants deciduous t	$25
D7140	Extraction erupted tooth/exr	$29
D7210	Rem imp tooth w mucoper flp	$186
D7220	Impact tooth remov soft tiss	$226
D7230	Impact tooth remov part bony	$301
D7240	Impact tooth remov comp bony	$371
D7241	Impact tooth rem bony w/comp	$457
D7250	Tooth root removal	$194
D7260	Oral antral fistula closure	$561
D7261	Primary closure sinus perf	$655
D7270	Tooth reimplantation	$78
D7272	Tooth transplantation	$155
D7280	Exposure impact tooth orthod	$390
D7281	Exposure tooth aid eruption	$258
D7282	Mobilize erupted/malpos toot	$46
D7285	Biopsy of oral tissue hard	$42
D7286	Biopsy of oral tissue soft	$42
D7287	Cytology sample collection	$30
D7290	Repositioning of teeth	$23
D7291	Transseptal fiberotomy	$37
D7310	Alveoplasty w/ extraction	$26
D7320	Alveoplasty w/o extraction	$70
D7340	Vestibuloplasty ridge extens	$170
D7350	Vestibuloplasty exten graft	$344
D7510	I&d absc intraoral soft tiss	$48
D7520	I&d abscess extraoral	$105
D7530	Removal fb skin/areolar tiss	$74
D7540	Removal of fb reaction	$108
D7953	Bone Replacement graft ridge	Not Covered
D7960	Frenulectomy/frenulotomy	$112
D7971	Excision pericoronal gingiva	$58
D7972	Surg redct fibrous tuberosit	$45
D7995	Synthetic graft facial bones	BR
D7996	Implant mandible for augment	BR
D7997	Appliance removal	BR
D7999	Oral surgery procedure	BR
D9110	Tx dental pain minor proc	$89
D9210	Dent anesthesia w/o surgery	$55
D9211	Regional block anesthesia	$70
D9212	Trigeminal block anesthesia	$178
D9215	Local anesthesia	$31
D9220	General anesthesia	$302
D9221	General anesthesia ea ad 15m	$126
D9230	Analgesia	$54
D9241	Intravenous sedation	$339
D9242	IV sedation ea ad 30 m	$120
D9248	Sedation (non-iv)	$272
D9310	Dental consultation	$108
D9410	Dental house call	$30
D9420	Hospital call	$50
D9430	Office visit during hours	$17
D9440	Office visit after hours	$47
D9610	Dent therapeutic drug inject	$8
D9630	Other drugs/medicaments	$15**
D9910	Dent appl desensitizing med	$15
D9911	Appl desensitizing resin	$11
D9920	Behavior management	Not Covered
D9930	Treatment of complications	$24**
D9940	Dental occlusal guard	$167
D9941	Fabrication athletic guard	$45
D9950	Occlusion analysis	Not Covered
D9951	Limited occlusal adjustment	Not Covered
D9952	Complete occlusal adjustment	Not Covered
D9970	Enamel microabrasion	Not Covered
D9971	Odontoplasty 1-2 teeth	Not Covered
D9972	Extrnl bleaching per arch	Not Covered
D9973	Extrnl bleaching per tooth	Not Covered
D9974	Intrnl bleaching per tooth	Not Covered
D9999	Adjunctive procedure	BR

ORTHODONTICS

D8010	Limited dental tx primary	$135
D8020	Limited dental tx transition	$161
D8030	Limited dental tx adolescent	$258
D8040	Limited dental tx adult	$271
D8050	Intercep dental tx primary	$211
D8060	Intercep dental tx transitn	$305
D8070	Compre dental tx transition	$1,500
D8080	Compre dental tx adolescent	$1,500
D8090	Compre dental tx adult	$1,500
D8210	Orthodontic rem appliance tx	$111
D8220	Fixed appliance therapy habt	$129
D8660	Preorthodontic tx visit	$51**
D8670	Periodic orthodontc tx visit	$1,500
D8680	Orthodontic retention	$106
D8690	Orthodontic treatment	$64**
D8691	Repair ortho appliance	$62**
D8692	Replacement retainer	Not Covered
D8999	Orthodontic procedure	BR

**** or BR (By Report) -- may require clinical report to determine medical appropriateness. Orthodontia services and services related to orthodontia are subject to the $1,500 lifetime maximum. Initial placement of orthodontia appliances and ongoing adjustments are paid on a per month basis up to $125 per month until treatment is completed or the lifetime maximum is reached, whichever occurs first.**

APPENDIX D

DEFINITIONS

Unless indicated otherwise in a specific context, words used in this booklet shall have the meanings set forth in this Appendix D. 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. **"Active Work"** means the performance of work as an Eligible Member at such place as is required in the course of his employment.

2. **"Active Classification"** means the following classes of individuals:

   - Qualified actively working members
   - Qualified members covered by the Minimum or Difference Self-Payment provisions
   - Self-employed members actively at work

3. **"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.

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

5. **"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:

   - It requires a licensed anesthesiologist to administer anesthesia and remain present during surgical procedures.
   - It provides at least two operating rooms and one post-operative recovery room.
   - It has X-ray and laboratory equipment.
   - It maintains written agreements with a hospital or hospitals concerning immediate admittance of patients who develop complications.
   - It maintains adequate medical records for each patient.
   - The facility does not provide accommodations for overnight stay.

6. **"Average semiprivate room rate"** means one of the following:

   - The most common charge by a hospital for semiprivate room and board accommodations.
   - The average semiprivate charge by hospitals in the area, where the hospital does not provide any semi-private room accommodations, but in no event more than the actual charge made by the hospital. The term "area" means a geographic area as is necessary to obtain a representative cross-section of hospitals furnishing patient care.

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

8. **"Carpenters' Pension Plan or related plan"** means the Pension Plan of the Carpenters' Pension Trust Fund of St. Louis or the Illinois Carpenters' Pension Plan.

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

10. **"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, by the In-Network or Out-of-Area Network, for medical care, services or supplies that:

    - are prescribed by a physician and are necessary in connection with the therapeutic treatment of the injury or sickness involved,

- are listed as Covered Charges and are not excluded from payment of benefits by the Exclusions and Limitations of the Plan,
- are recognized as generally accepted medical practice, and
- are not in excess of the reasonable and customary charges for the same or similar medical care, services, and supplies.

11. **"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.

12. **"Custodial care"** means expenses incurred for care consisting of accommodations (including room and board and other institutional services) or nursing services provided to an individual because of age or other mental or physical conditions in order to assist the individual in activities of daily living.

13. **"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.

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

15. **"Educational Therapy"** is therapy intended to further or promote the covered individual's education or intended to educate the covered individual.

16. **"Eligibility Classes"** means the category or class a covered person becomes qualified for and maintains coverage.

17. **"Eligible for Medicare"** means that an individual is eligible to participate in the Medicare program by reason of attained age and/or entitlement to Social Security benefits.

18. **"Emergency"** means:
    - an acute or sudden illness or injury that without immediate medical care could result in death or cause serious impairment to bodily functions,
    - a medical situation which if not promptly addressed could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function, or
    - a medical situation which in the opinion of a physician with knowledge of the individual's medical condition, would, if not promptly addressed, subject the individual to severe pain that cannot be adequately managed without prompt care or treatment.

19. **"Employer"** means employer as defined in the Carpenters' Health and Welfare Trust Fund Agreement.

20. **"Entitled to Medicare"** means that an individual is both Eligible for Medicare and enrolled in Part A or Part B of Medicare.

21. **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

22. **"Experimental or investigative"** means in connection with a drug, device, treatment or procedure that:
    - with respect to the illness being treated, the drug, device, treatment, or procedure cannot be lawfully marketed in the U.S. or has not been approved by the U.S. Food and Drug Administration (FDA) at the time the drug or device is furnished; or
    - with respect to the illness being treated, the drug, device, treatment or procedure, or the patient informed consent document used with the drug, device, treatment or procedure, requires review

and approval by the treating facility's Institutional Review Board or other body serving a similar function, or if U.S. federal law requires such review and approval; or

- with respect to the illness being treated, reliable evidence shows that the prevailing opinion among experts in the appropriate field regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

- 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.

23. **"FMLA"** means the Family and Medical Leave Act of 1993.

24. **"Home health agency"** means a public or private agency or organization, or a 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.

25. **"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.

26. **"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.

27. **"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.

28. **"In-Network provider"** means the hospitals, physicians and other clinical facilities who have a written agreement with the In-Network 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.

29. **"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.

30. **"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.

31. **"Intensive care accommodation"** means an accommodation exclusively reserved for critically and seriously ill or injured patients requiring special and close observation as prescribed by the attending physician. Such accommodations include room and board, specialized registered nurse (RN) and other nursing care, special equipment or supplies immediately available on a stand-by basis and is segregated from the rest of the hospital's facilities.

32. **"Managed Mental Health Care Company"** means the organization with whom the Carpenters' Health and Welfare Trust Fund has contracted to administer the Managed Mental Health Care program.

33. **"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.

34. **"Medical Care Management Company"** means the organization with whom the Carpenters' Health and Welfare Trust Fund has contracted to administer the Managed Care program.

35. **"Medically necessary," "medical necessity,"** or **"necessary"** means a level, amount and type of care provided for the diagnosis or treatment of a injury or sickness that is necessary and appropriate according to the standards of medical practice in effect in the United States on the date a particular service or supply is rendered or received.

36. **"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.

37. **"Medicare"** means the federal program of Health Insurance for the Aged and Disabled, otherwise referred to as Title XVIII of the Social Security Act.

38. **"Mental and nervous condition"** means a psychotic disorder, a psycho-physiologic autonomic or visceral disorder, a psycho-neurotic disorder, a personality disorder, a transient situational personality disorder, or any other medically recognized mental, emotional or functional nervous disorder of any type.

39. **"Network"** means one of the organizations with which the Carpenters' Health and Welfare Trust Fund has contracted to gain access to providers of medical care, services and supplies for plan participants. There are several Networks: the In-Network for medical care in this geographic area, the Out-of-Area Network for medical care outside the geographic area, the Pharmacy Network, the Mental Health Network, and the Vision Care Network. See pages 63-64, for names of each.

40. **"Network provider"** means the hospitals, physicians, clinical facilities, pharmacies and vision care providers that have written agreements with one of the Networks 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 any of the Networks at any time to determine a provider's participation status. A Network provider may be an In-Network provider, an Out-of-Area provider, or both.

41. **"Non-Active Classification"** means the following classes of individuals:

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

42. **"Non-Bargained Office Employee"** means any full-time employee of a contributing employer who executes a Participation Agreement For Non-Bargained Office Employees and is accepted by the Trustees other than:

    - An employee covered by a collective bargaining agreement requiring contributions to this plan or another health and welfare plan, or
    - Partner or sole proprietor of the employer and any other person who is prohibited by law from participating in this plan.

43. **"Non-Network provider"** means the hospitals, physicians, clinical facilities, pharmacies and vision care providers that do not have written agreements with the relevant Network to provide health care services and supplies to plan participants for a negotiated charge.

44. **"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.

45. **"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.

46. **"Out-of-Area Network provider"** means the hospitals, physicians and other clinical facilities located outside the geographical area defined in Appendix F who have a written agreement with the Network with which the plan has contracted 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.

47. **"Outside Eligibility Class"** means a 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.

48. **"Pharmacy Benefit Manager"** means the organization with whom the Carpenters' Health and Welfare Trust Fund has contracted with to administer the Prescription Drug Program.

49. **"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.

50. **"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.

51. **"Plan Year"** shall commence on May 1 of one year and end on April 30 of the succeeding year.

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

53. **"Provider"** means a physician, hospital, or other provider of medical care, services or supplies.

54. **"QMCSO"** means a Qualified Medical Child Support Order, as defined in Section 609(a) of ERISA, added by the Omnibus Budget Reconciliation Act of 1993, effective August 10, 1993.

55. **"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.

56. **"Skilled nursing facility"** means a legally-operated institution that:

- specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis,
- maintains on the premises specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis,
- maintains on the premises all facilities necessary for medical treatment,
- for a fee provides convalescents with room, board and 24-hour skilled nursing care by one or more professional nurses and other nursing personnel needed to provide adequate medical care,
- is under 24-hour supervision of a physician or registered graduate nurse (RN),
- keeps adequate daily medical records for each patient,
- if not operated by a physician, has the services of one available under an established agreement, and
- is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, drug addicts, alcoholics, or a facility for custodial care, remedial education or training.
- specializes in physical rehabilitation, skilled nursing and medical care on an inpatient basis,
- maintains on the premises all facilities necessary for medical treatment,
- for a fee provides convalescents with room, board and 24-hour skilled nursing care by one or more professional nurses and other nursing personnel needed to provide adequate medical care,

- is under 24-hour supervision of a physician or registered graduate nurse (RN),
- keeps adequate daily medical records for each patient,
- if not operated by a physician, has the services of one available under an established agreement, and
- is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, drug addicts, alcoholics, or a facility for custodial care, remedial education or training.
- all facilities necessary for medical treatment,
- for a fee provides convalescents with room, board and 24-hour skilled nursing care by one or more professional nurses and other nursing personnel needed to provide adequate medical care,
- is under 24-hour supervision of a physician or registered graduate nurse (RN),
- keeps adequate daily medical records for each patient,
- if not operated by a physician, has the services of one available under an established agreement, and
- is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, drug addicts, alcoholics, or a facility for custodial care, remedial education or training.

57. **"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.

58. **"Speech therapy"** means the remediation or rehabilitation for speech and language impairments.

59. **"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.

60. **"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.

61. **"Trustees"** shall mean the Trustees under the Trust Agreement.

62. **"Union"** means union as defined in the Carpenters' Health and Welfare Trust Fund Agreement.

APPENDIX E

HIPAA – PRIVACY PRACTICE PRACTICES

This Section describes how the Carpenters' Health and Welfare Plan of St. Louis can use or disclose Medical Information about you. It also describes how you can get access to your Medical Information. Please review this carefully.

Under federal law, group health care plans are required to notify participants and beneficiaries in a group health plan about how the Plan will use and disclose "individually identifiable health information" (described below) which it maintains on your behalf. The federal requirements are set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

"Individually identifiable health information" is also referred to in the law as "protected health information (PHI)" which includes:

> . . . information maintained by a health care provider, health plan, employer, or health care clearinghouse which relates to past, present, or future physical or mental health or condition of an individual . . . that identifies the individual or as to which there is a reasonable basis to believe the information can be used to identify an individual (emphasis added – Section 164.501 of the privacy rules).

HIPAA requires that your group health plan maintain the confidentiality of PHI in accordance with federal regulations. HIPAA also requires the plan to notify participants and beneficiaries about their privacy rights which is the purpose of this notice. The Trustees of the Carpenters' Health and Welfare Trust Fund of St. Louis (the "Plan") urge you to read this Appendix E in its entirety so that you are fully aware of your privacy rights. The contents of this Section became effective April 14, 2003.

The use of the word "you" in the notice refers to individual participants and covered dependents in the plan. To make reading this notice easier, certain abbreviations are used such as: PHI – protected health information, and GHPs – group healthcare plans. Occasionally a reference is made to a specific section in the applicable federal regulations; the full text of these sections may be obtained from the Fund Office.

USE OF PHI WITHOUT YOUR CONSENT

Under the federal privacy law and related regulations, the plan is permitted, and in some cases required, to use and disclose your PHI without your consent or authorization for the following purposes: (1) your treatment; (2) processing and payment of your claims; and (3) health care operations. An example of these purposes follows.

Treatment

A service provider will often need to check with the Fund Office to make sure you are eligible for coverage or, a service provider may need to know from the plan who has treated you previously, what the earlier diagnosis was, and what treatment was prescribed. The Plan is permitted to provide such PHI to the service provider without your consent.

Claims Processing and Payment

The plan usually receives a bill from each service provider who treated you (e.g. hospital, physician, lab, clinic, etc.) containing a diagnosis code and a treatment code for a specific patient. This is PHI. The plan uses this information to process the claim on the computer and to generate a check for the appropriate payment of the service provider in accordance with the plan's rules.

Health Care Operations

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

When the plan provides PHI to another entity for any of the purposes listed above, the plan will make reasonable efforts to limit the PHI provided to the "minimum necessary", as that term is defined in Section 164.502(b) of the final privacy rules.

Other Purposes for Which Your PHI May Be Used Without Consent

In addition to the purposes described above, there are a number of other purposes for which the plan may use or disclose, or may be required to disclose, your PHI without obtaining advance consent or authorization from you. These include (but are not limited to):

- Responding to public health agencies authorized by law to collect or receive health information for the purposes of preventing or controlling disease, injuries, or disabilities.
- Responding to public health agencies or social service agencies or protective services agencies authorized by law to receive reports of child abuse, neglect, or domestic violence.
- Responding to an employer's request if the employer needs to know if his employee has suffered a work-related illness or injury.
- Responding to the Trustees' request for PHI if the Trustees need such information for review of a denied claim or for an assessment of a plan's benefit costs by type of health care services provided.
- Responding to a request from a health oversight agency authorized by law to conduct: audits; civil, administrative, or criminal investigations; inspections; licensure of or actions against health care providers; or other activities designed to protect the health care system.
- Responding to inquiries from law enforcement agencies that require reporting of certain kinds of wounds or physical injuries or to assist with the identification or location of a suspect, fugitive, material witness, or missing person.
- Responding to inquiries from correctional institutions or lawful officials having custody of an inmate, if the PHI is necessary to protect the health of the inmate or other inmates and employees at the correctional institution.
- Responding to inquiries from organ procurement organizations who are engaged in the procurement, banking or transplantation of cadaver organs, eyes, or other tissues.
- Responding to requests from health research agencies, whether privately funded or funded by government. (However, use of PHI by a research agency is closely monitored by other review boards and is subject to a complex array of other federal regulations.)

Use or Disclosure of PHI Requiring Your Authorization

Except as otherwise permitted or required above, the plan may NOT use or disclose any PHI without your authorization.

For example, if you are being treated for a mental illness, the plan is NOT authorized to release any psychotherapy notes related to your case without your consent. The plan is permitted, however, to use PHI for purposes of your treatment or processing of your claim without your consent (except for the psychotherapy notes).

If you wish to authorize the release of psychotherapy notes or any other PHI requiring your consent, contact the Fund Office for an Authorization Form. The Form will ask you what PHI may be disclosed, who may receive designated PHI, when the Authorization expires, and indicate your right to withdraw the Authorization under certain conditions.

Your Rights Regarding Access to Your Own PHI

You may request that restrictions be placed on the uses and disclosures of your PHI for treatment, payment of claims or health care operations in accordance with Section 164.522(a) of the privacy rules. Your request must be submitted to the Fund Office in writing.

However, the plan is NOT required to agree to a requested restriction if the plan accepts your restriction, the plan may be required to release such information for emergency treatment, law enforcement, or other purposes specified by state and/or federal laws.

You may terminate a restriction at any time, either orally or in writing. Otherwise, the plan will keep the restriction in affect for up to six years after it is first filed.

You may ask to inspect or to copy your PHI found in a "designated record set".

A "designated record set" is:

- the medical records and billing records maintained by the plan about each participant or by a health care provider; and
- enrollment, payment, claims adjudication, and care management records maintained by the plan on individual participants and beneficiaries.

Generally the plan will not have detailed medical records per se but will have only computer coded data needed to process a claim submitted by a health care provider.

If you wish to examine or copy a designated record set, the request must be in writing. The plan will arrange a convenient time and place for you to inspect and/or copy the PHI requested. The plan will discuss with you in advance the scope, format, and other aspects of the request in order to facilitate the timely provision of the requested PHI. Access will be provided no less than 30 days after the request is first

received by the Fund Office (unless the PHI is not readily available at the Fund Office, in which case a 60-day time limit applies).

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

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

You have the right to request to amend your own PHI if you believe it is inaccurate or incomplete in accordance with the procedures set forth in Section 164.524 of the privacy rules.

The request must be submitted in writing on a form provided by the plan. The plan will respond to your request for correction of your PHI within 60 days after receipt of your request. If approved, the plan will notify other parties (such as health care providers or clearinghouses) about any corrections in your PHI if necessary to prevent any subsequent actions which may be detrimental to your health care.

If the change is disapproved by the plan, you will be notified in writing about the reason(s) for denial of your request, about your right to disagree with the denial, and about the appeal procedures. A participant may request that his letter of disagreement be included with any future disclosure of his or her PHI.

You have the right to request an accounting of any disclosure of your PHI made by the plan requiring your consent or authorization for such disclosure.

The accounting will include: the date of the disclosure; the name and address of the entity or person to whom your PHI was disclosed; a brief description of the PHI disclosed; the reason for the disclosure or a copy of your signed authorization for the disclosure. The plan will provide this information within 60 days after your request is received by the Fund Office.

Parent's Access to Their Children's PHI

Under the privacy rules, a parent usually acts as a "personal representative" of his or her child and, as a result, has authority to access or to amend his or her child's PHI. However, there may be exceptions under state law or other law. For example, some states do NOT require consent of a parent or other persons before a minor can obtain a particular health care service (such as mental health treatment). Or, a court may grant authority to make health care decisions to an adult other than the parent. These are issues best discussed with your own attorney if the need arises.

What the Plan is Prohibited from Doing Without Your Authorization

The Plan or any entity performing services for the Plan (such as an insurance company or third party administrative firm) is NOT permitted to give or sell lists of patients or enrollees to a telemarketer, door-to-door salesmen or other entity unless that entity has agreed by contract with the Trustees of your plan to use the information only for informing you about the health care services and/or supplies provided by the plan.

If a plan markets particular goods and services to participants, the plan is required to identify itself as the party making the communication, indicate whether the plan has received or will receive direct or indirect remuneration for making the communication, and except when the communication is contained in a newsletter or other general communication to all participants, offer you the opportunity to opt out of receiving any future marketing information.

The plan is also permitted to use or disclose PHI to identify participants in a particular target group to receive marketing information based on their health status or condition (e.g., a communication intended for all diabetics or for all arthritis patients), as long as the communication clearly states why you have been targeted and how the product or service relates to your health. You may opt out of any future communications related to your specific health condition.

Plan's Right to Change Privacy Practices

Until further notice, the plan will maintain the privacy of PHI in accordance with the rights and requirements set forth in this Appendix E. However, the plan reserves the right to change the terms of this Appendix E at any time and to make the new terms effective for PHI that it maintains.

Notice of revised procedures will be distributed to individuals via first class mail (and e-mail, if applicable) at least 30 days before the effective date of the new procedures. (Any revised notice will also appear in the Cutting Edge).

A copy of the latest notice regarding the plan's privacy practices may be obtained anytime by contacting the Fund Office by letter, phone, fax, or e-mail.

MEDICARE PART D DISCLOSURE– MEDICARE MODERNIZATION ACT (MMA)

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

Need Help?

If you have any questions concerning your privacy rights, want to exercise any of those rights, or want to complain about a violation of those rights, contact the Fund Office by phone at (314) 644-4802 or toll-free (877) 232-3863, by fax (314) 644-0200, by e-mail benefits@carpdc.org, or by letter addressed to:

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

PLEASE ADDRESS YOUR REQUEST TO THE FUND'S "PRIVACY OFFICER".

If you are not satisfied with the answer(s) received from the Fund Office, you may wish to contact the U.S. Department of Health and Human Services (HHS) in Washington, D.C. Ask the Fund's Privacy Officer for the name and address of the appropriate HHS contact person. The plan will not take any adverse action against any participant or beneficiary who decides to contact the HHS directly.

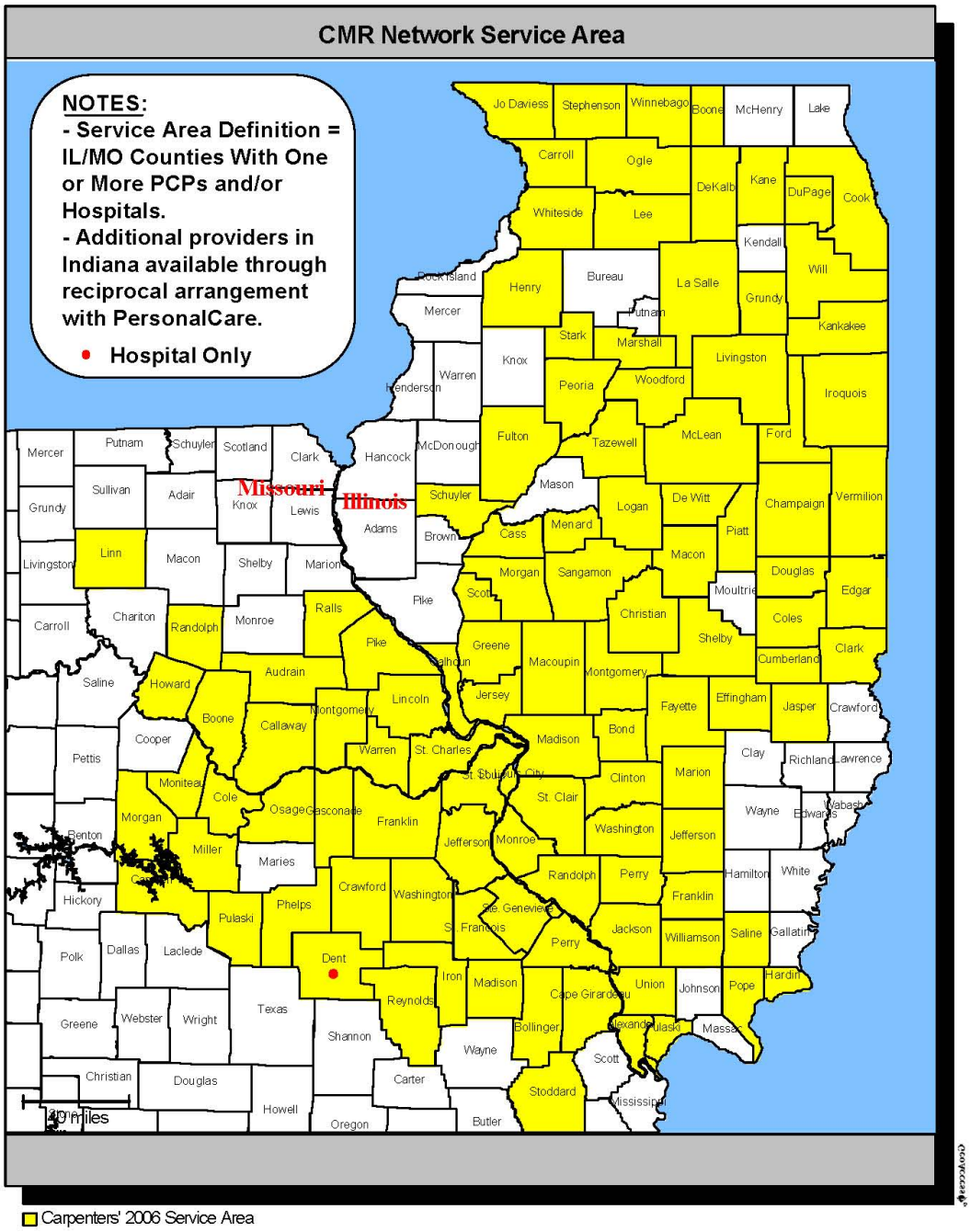
A FINAL REMINDER

The Fund Office staff will make every reasonable effort to protect the confidentiality of your medical data in accordance with federal laws and regulations. If you have questions or complaints, please contact the Privacy Officer at the Fund Office first.

APPENDIX F

IN-NETWORK SERVICE AREA

Carpenters' Health and Welfare Trust Fund



OUT OF AREA NETWORK SERVICE AREA

First Health Network

The First Health Network is a nation-wide network, whose providers are reimbursed at the Out-of-Area Level of Benefits.

The First Health Network is not available in the following counties:

Illinois: Madison, Monroe, St. Clair

Missouri: St. Louis, St. Charles, Jefferson, St. Louis City

APPENDIX G

PRESCRIPTION DRUG PLAN

Members may obtain up to a 90-day supply at retail and mail pharmacies.

Direct Member Reimbursement (DMR): Reimburse at the lower of contracted or submitted rate with one co-payment per 30-day supply up to 90 days maximum.

Plan has a $2,500 annual out-of-pocket (OOP) maximum per family.**

Generic Drugs:
- Up to 30-day supply: 20% ($50 co-payment maximum per prescription)
- 31-90 day supply: 20% ($100 co-payment maximum per prescription)

Brand Name Drugs **without** Generic Equivalent available:
- Up to 30-day supply: 30% ($50 co-payment maximum per prescription)
- 31-90 day supply: 30% ($100 co-payment maximum per prescription)

Brand Name Drugs **with** Generic Equivalent available:
- Up to 30-day supply: Difference in cost* **plus** 20% of Generic cost.
- 31-90 day supply: Difference in cost* **plus** 20% of Generic cost.

* **Difference in Cost:** When a Multi-source Brand drug is purchased, patient will pay 20% of the cost of the Generic medication up to the applicable co-payment maximum **PLUS** the difference in the cost between the Generic and the Multi-source Brand drug. The Plan will pay 80% of the cost of the Generic medication, just as if the patient purchased the Generic medication. In this way, the Plan allows the patient to purchase the Multi-source brand drug without negatively impacting the overall cost to the plan. The **Difference in cost *does not* count toward OOP or co-payment maximum.**

Members under the Carpenters' Medicare Supplement Plan have a $2,500 annual out-of-pocket (OOP) maximum ***per member* plus catastrophic coverage member cost sharing when the OOP is reached. The catastrophic cost sharing is the greater or 5% or $2 for generics and multi-source brand drugs and $5 for single source brand drugs.

ACTIVE MEMBERS

CLINICAL CARE MANAGEMENT PROTOCOLS EFFECTIVE JANUARY 1, 2006

Starter Quantity Program

The Starter Quantity Program is designed so that coverage for any new prescription is limited to a quantity prescribed by your physician not to exceed a 30-day supply before becoming eligible for larger quantities. A covered new prescription is described as:
- a change in drug strength or dosage,
- more than six month's lapse since last coverage for that drug, or
- coverage for a medication that has not been covered for that person before.

The purpose of the Starter Quantity Program is to make sure any new medications prescribed to you perform the way you and your doctor expect. Once you are sure the new medication is effective without untold side-effects, you may order a large supply. This program prevents large quantities of medications from being covered that are unable to be used.

First Line Treatment Programs

First line treatment programs require the "first line" or proven medications, often generic, be tried prior to obtaining newer, less proven "second line" medications. All members taking the second line medications prior to January 1, 2006 may continue with their therapy and will not be required to meet the first line treatment requirements.

1. **Anti-arthritic First Line Treatment:** A traditional Non-Steroidal Anti-Inflammatory Agent (NSAID), such as Ibuprofen, must be tried prior to receiving coverage for a COX-2 medication.
2. **Anti-arthritic Injectables First Line Treatment:** Requires a patient must try methotrexate or other disease-modifying anti-rheumatic drug (DMARD) before receiving coverage for Enbrel or Humira. The manufacture recommended guidelines suggest a DMARD be attempted as first line treatment.
3. **Depression First Line Treatment:** It is recommended a patient seek counseling in conjunction with taking an antidepressant. Antidepressants have the ability to provide benefits if taken correctly, however, there is no one drug that is a "medication of choice". The Depression First Line Treatment

Program requires a patient receiving coverage for the treatment of their depression to start with traditional generic medication treatment options first, before obtaining coverage for newer, less-proven treatments.

4. **Gastrointestinal/Acid Peptic First Line Treatment:** Research has shown the administration of histamine H2-receptor antatagonists (Zantac;Tagamet/Axid/Pepcid/Prevpac) in standard divided doses can achieve complete symptom relief and heal the esophagitis in patients with gastro esophageal reflux disease (GERD) and peptic ulcer disease. Newer medications called PPIs have also been proven effective in the treatment of acid peptic disorders, however H2 treatments are recommended as the first line of treatment because of their safety, effectiveness, and cost. In order to qualify for coverage of a PPI medication (example, Nexium) a patient must have tried and failed with treatments of an H2-Antagonist and generic PPI, such as Omeprazole (generic for Prilosec) within the last six months.
5. **Hypertension First Line Treatment:** Research sponsored by the National Heart, Lung and Blood Institute studying treatment options for high blood pressure found the first line of treatment for high blood pressure should be a diuretic. And if you need multiple drugs to control your high blood pressure, one on the medications should be a diuretic. Coverage for hypertension will be restricted to a diuretic as the first line of treatment unless other existing medical conditions or medications require other drug therapies.

Supply and Dosage Limit Program

1. **Anti-fungal Lifetime Supply Limit:** Indications are that nail fungus treatment drugs prescribed such as Lamisil be limited to a life-time supply of 90 days. Medical literature indicates if the condition is not cured within the 90-day treatment period, it will not benefit the patient to continue taking these medications. Therefore, antifungal medications are limited to 90 days lifetime. Prior authorization is required for coverage of quantities in excess of those guidelines.
2. **Anti-migraine Medication Dose Management:** Studies have shown anti-migraine medication in doses higher than manufacturer guidelines may actually cause the migraines they are intended to treat. Coverage is limited to the guidelines provided by the National Headache Foundation. Prior authorization is required for coverage of quantities in excess of the manufacturer's guidelines.
    a. Amerge: 1 mg and 2.5 mg - (9) tablets per 30 days; regardless of strength.
    b. Axert: 6.25 mg and 12.5 mg - (12) tablets per 30 days; regardless of strength.
    c. Frova: 2.5 mg - (12) tablets per 30 days.
    d. Imitrex: 25 mg, 50 mg, and 100 mg - (9) tablets per 30 days; regardless of strength.
    e. Imitrex Nasal Spray: (12) units or (2) packages per 30 days.
    f. Imitrex Injections: (12) injections or (6) kits per 30 days.
    g. Maxalt: 5 mg and 10 mg - (12) tablets per 30 days; regardless of strength.
    h. Migranal Nasal Spray: (8) units or (2) kits per 30 days.
    i. Zomig: 2.5 mg and 5 mg - (12) tablets per 30 days; regardless of strength.
    j. Replax: 20 mg, 40 mg, and 80 mg - (9) tablets per 30 days; regardless of strength.
3. **Insomnia Medication Dose Management:** Certain insomnia medications (Ambien, Sonata) are used to treat acute insomnia, but are not indicated for long-term maintenance or chronic therapy. Therefore, as recommended by the manufacturer, the following quantity limits will apply:
    a. **Ambien and Sonata** –Limited to a quantity of 14 regardless of dosage per 30-day supply and each claim is limited to a 30 day supply.
    b. **Lunesta and Rozerem** – Limited to a quantity of 30 tablets per 30-day supply and each claim will be limited to a 30-day supply.

    All coverage for additional insomnia medications must receive prior authorization and are subject to the plan's refill utilization parameters.

MEDICARE SUPPLEMENT MEMBERS

Clinical Care Management Protocols: We are encouraging Medicare Supplement Members to follow the guidance of the Clinical Programs as described under the Active Member section above. These programs are designed to help you obtain the most cost-effective, and appropriate medication to meet your health care needs while helping to avoid potential adverse effects certain medications can cause. These are proven programs established by physicians, pharmacists and other experts in the healthcare field. Due to their intended benefits, you should also know that the Plan will likely make these programs mandatory for Medicare Supplement members sometime in 2006.

CREDITABLE COVERAGE DISCLOSURE FOR PRESCRIPTION DRUG PLANS OFFERED TO THE ACTIVE AND RETIREE POPULATIONS

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare.

You and/or your dependent have a decision to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. This notice provides important information that will help you to make your decision. **Please read this carefully, and keep it where you can find it as you may need it for future use.**

One of the key factors in determining if a Medicare prescription drug plan is right for you and/or your dependent has to do with whether the coverage you currently have is "creditable coverage" or "non-creditable coverage." Creditable coverage means that the prescription drug coverage you receive is on average at least as good as the standard Medicare prescription drug coverage. In other words, it will pay out as much or more than the standard Medicare coverage. Non-creditable coverage is not as good and is not expected to pay out as much as Medicare coverage. **It has been determined that the prescription drug coverage offered by the Carpenters' Health and Welfare Plan does qualify as Creditable Coverage.**

The Centers for Medicare and Medicaid Services (CMS) has approved the Carpenters' Health and Welfare Trust Fund of St. Louis (Carpenters') to provide Medicare Part D prescription drug coverage as a certified Union PDP (Prescription Drug Plan) for Medicare Supplement participants.

Active Employees or Pre-65 Retirees

If you are currently Medicare eligible or become eligible for Medicare this year, but remain covered as an active participant in the Carpenters' Health and Welfare Plan and enroll in a Medicare Part D plan, Carpenters' will continue to be the primary payer and Medicare Part D will be secondary.

When you move from the Carpenters' Active Plan to the Carpenters' Medicare Supplement Plan, you are automatically enrolled in the Medicare Part D plan through Carpenters'. If you are enrolled through another Medicare Part D Plan prior to moving to the Carpenters' *Medicare Supplement* Plan, the other Medicare Part D coverage will be terminated and you will only have Medicare Part D through the Carpenters' Medicare Supplement Plan. **You can only be enrolled in one Medicare Part D Plan**. However, if you enroll in another Medicare Part D Plan while you are covered under the Carpenters' Medicare Supplement Plan, the Carpenters' Plan will be terminated (see Reinstatement Provisions – Non-Active Classification on page 11).

You should compare your current coverage with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Be sure to look at and compare which drugs are covered under different plans.

If you drop or lose your coverage with Carpenters', you should enroll in Medicare Part D coverage immediately. Waiting to enroll can be costly. After May 15, 2006, if you go 63 days or longer without creditable prescription drug coverage, your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll. The annual enrollment period for Medicare prescription drug plans is from November 15, 2005 through May 15, 2006, and then from November 15-December 31 for each year thereafter.

Medicare's Low Income Subsidy (LIS) Program: For people Medicare has determined to meet the limited income and resources qualifications, extra help paying for Medicare premium and prescription drug costs is available. Information about this extra help is available from the Social Security Administration (SSA). For more information or to see if you qualify, visit SSA online at www.ssa.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Carpenters' District Council
1401 HAMPTON AVENUE
ST. LOUIS, MO 63139
(314) 644-4800
(800) 332-7188
WWW.CARPDC.ORG

Carpenters' Benefit Offices
1419 HAMPTON AVENUE
ST. LOUIS, MO 63139
(314) 644-4802
(877) 232-3863
WWW.STL-CARPENTERBENEFITS.ORG

Important Numbers:

Carpenters' Benefit Office Extensions

- Member Service Department . . . . . Ext. 1000
- Pension Department. . . . . Ext. 1001
- Care Management . . . . . Ext. 1002
- Estamp Department . . . . . Ext. 1030
- Legal Advice Appointments . . . . . Ext. 296

Care Management Resources (CMR) – www.cmrnetwork.com

- Utilization Review . . . . . (800) 546-4603
- Customer Service . . . . . (800) 775-3540

Unity Mental Health & MAP - www.unitymap.com

(314) 729-4600 (local)
(800) 413-8008 (toll-free)

Vision Service Plan – www.vsp.com

(800) 877-7195 (toll-free)

Medicare Complete - www.medicarecomplete.com

(888) 867-5548
(888) 685-8480 (TDD)

Gold Advantage – www.ghpmedicare.com

(800) 533-0367

Pharmacy

PharmaCare (Retail) - www.pharmacare.com

(888) 645-9303

MedScripts (Mail-Order) - www.stjohnsmercy.org/services/medscript

(314) 427-0756

Other Numbers:

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